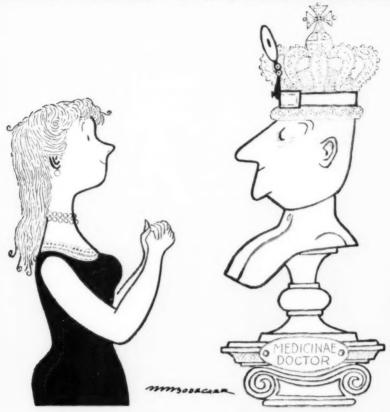
# **Medical Economics**



How to Be a Doctor's Wife

Also in this issue:

No Bottlenecks in This Office They Pool Their Charity Giving Hazards of Owning Property Jointly

# With Nitranitol hypertensives can return to a more normal life...sooner



Restricted activity and frequent laboratory checkups are often a concern to the patient. You can return many hypertensives to a more normal life with Nitranitol. Because of its low toxicity, blood pressure is safely lowered-side effects are the exception rather than the expected. Nitranitol acts directly on the arterioles to produce gradual vasodilation. It maintains lowered pressures for prolonged periods.

Why not start your hypertensive patients on Nitranitol - the universally prescribed drug for essential hypertension.2



Because of its direct action on the arterioles, Nitranitol provides SAFE, GRADUAL, PRO-LONGED vasodilation, in 5 dosage

Nitranitol
Mannitol hexanitrate 32 mg.

Vasodilation plus sedation: Nitranitol with Phenobarbital

Mannitol hexanitrate 32 mg. Phenobarbital . . . . . 16 mg. Protection in capillary fragility: Nitranitol

with Phenobarbital and Rutin° ..... 20 mg. with Rutin . . .

When threat of cardiac failure exists: Nitranitol with Phenobarbital

and Theophylline\* with Theophylline . . 100 mg.

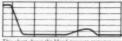
For refractory cases of hypertension: Nitranitol P. V. with Alkavervir.

(A special alkaloidal fraction Veratrum viride, biologically standardized for hypotensive activity.)

\*Each contains Nitranitol 32 mg. and Phenobarbital 16 mg.

DOSAGE: In blood pressures over 200 systolic, 2 tablets 4 times daily. In other cases, 1 or 2 tablets every 4 to 6 hours.

NOTE: Nitranitol is exceptionally stable, assuring potency, so in portant in hypertensive medication.



The Wm. S. Merrell Company . . . Pioneer in Medicine for 125 Years.

Publ cal E Orch

# September 1953

# **Medical Economics**

Do Druggists Supply What You Prescribe? Many of them don't, according to this report. Instead, the problem of Rx substitution seems to have grown to shocking proportions	
Eight Steps to Take After an Auto Accident This check list may save you costly legal complications	
No Bottlenecks in This Four-Man Office It features a streamlined treatment area that's designed to save the doctors' time and energy	104
How to Be a Doctor's Wife  'The smooth functioning of a physician's office can be upset as much by a poorly oriented wife as by an incompetent secretary,' says the writer. So here's her advice to an M.D.'s prospective bride	114
Insurance Proceeds: When Are They Taxable?  Some must be reported as income; others needn't be. A tax man tells you how to draw the line	121
Trial by Twister	124
Who's Boss in Your Office?	134
At the Head of the Class: a Showman	140
They're Lowering State Licensure Barriers What with keeping standards up, it's a long, slow process. But already it's getting easier for doctors to move	142

Published monthly and copyrighted 1953 Medical Economics, Inc., 210 Orchard St., East Rutherford, N.J.

MORE ON NEXT PAGE

# CONTENTS (Cont.)

They Pool Their Giving	153
By uniting to make their donations to charity, these doctors save time and uncertainty—and give more	
If They Don't Know, Nobody Does	161
With 650,000 volumes to choose from, librarians at the Armed Forces Medical Library can generally come up with the right answer to any query you send them	
Tax Deductions on Rental Income	171
If you're a landlord, you know maintenance costs have risen-reason enough for saving all you can on taxes	
Statute of Limitations Isn't Always a Safeguard	179
You may know what the time limit is on initiating mal- practice suits in your state. But are you aware that that limit doesn't always hold?	
Four Easy Ways to Lose an Associate	184
Finding a good M.Dassociate is only part of it. The real trick's in keeping him	
Patients Enjoy Getting This G.P.'s Bills	194
Here's a new recipe for smooth patient relations: Keep them posted on medical matters with a monthly newsletter	
Hazards of Joint Ownership	207
Are You Insured Against Liability Claims?  If so, do you know what protection your policy gives— and doesn't give? This article should open your eyes	223
DEPARTMENTS	
Panorama 4	
Sidelights	
Questions	
Editorial	

Memo From the Publisher ...... 296

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# NEWS INDEX

State Supreme Court Rules On \$45 Bill	246
Extols 'Deductible' Blue Cross Plan	246
Cultists Advised to Tone Down Ads	251
Urges Credit for Men Behind Microscopes	251
'Cheap Repair Jobs Are No Bargain'	253
Operating Room Named for 'Grand Old Man'	254
Hawley Cites Needless Surgery By Two M.D.s	258
Find Insurance Covers Most Hospital Days	262
Dollar Drive Urged for Mental-Disease Study	265
Propose Ethics Changes to Fight Panel Plans	267
'Happy' British Doctor Profiled In Lay Press	271
Outlines Easy-Does-It Fee Approach	275
'U.S. Still Menaced by Socialized Medicine'	

EDITOR-IN-CHIEF: H. Sheridan Baketel, M.D. EDITOR: William Alan Richardson EXECUTIVE EDITOR: R. Cragin Lewis COPY EDITOR: Donald M. Berwick ADMINISTRATIVE EDITOR: William T. Reich Associate Editors: Wallace Croatman Mauri Edwards ASSISTANT EDITORS: Lois Hoffman Mary G. James RESEARCH ASSOCIATE: Marguerite Hecking EDITORIAL CONTRIBUTORS: Henry A. Davidson, M.D. Roger Menges Jack Pickering ART DIRECTOR: Douglas R. Steinbauer

PUBLISHER:
LANSING Chapman
GENERAL MANAGER:
W. L. Chapman Jr.
SALES MANAGER:
RObert M. Smith
PRODUCTION MANAGER:
J. E. Van Hoven





PRICE: 50 cents a copy, \$5 a year (Canada and foreign, \$6). Acceptance authorized under Section 34.64 PL&R. CIRCU-LATION: 134,000 physicians and residents. PICTURE CRED-ITS (left to right, top to bottom): cover, 114-119, N. M. Bodecker; 5, 8, 137, 279, Wide World; 9, Leo Friedman; 104-113, Harry H. Baskerville Jr.; 123, William Klender-Sun Papers; 124, 125, Worcester Telegram-Gazette; 126, 129, Flint Journal; 127, United Press; 128, Marvin Richman-Wide World; 130, Windy Drum; 131, 133, Jimmie Willis; 140, 141, Vincent A. Finnigan; 146, 147, Ted F. Leigh, M.D.; 198, Bruno; 267, Photoreflex.

# Panorama

Doctor population at a

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record level • Almost \$2 million contributed to medical education • A.M.A. battles American Legion at Congressional hearing • Television post-graduate courses a possibility

# **Medical Deductions Urged**

Your patients apparently agree that it's time the Government allowed the deduction of all medical bills for income tax purposes. Pollster George Gallup recently quizzed the public about a measure that would do just that (H.R. 3911, introduced by Representative Oliver P. Bolton, Ohio Republican). He found that almost nine out of ten people favor such a blanket deduction.

# Premiums Set Record

A recent spurt puts the health and accident insurance business (in terms of premiums collected) ahead of fire and automobile insurance and in second place behind life insurance, which remains the greatest single segment of the industry.

Last year, the Accident Insurance Register reports, life and property insurance carriers collected net premiums for health and accident policies amounting to \$1.9 billion. That all-time peak is 18 per cent higher than the 1951 record and 206 per cent above the level of 1946.

Thus, say leaders in the business, a strong, new statistical support is placed under the belief that voluntary insurance is in large part the answer to the nation's health problem.

# Hawley Is A.M.A. Man

"Hawley Not Member, A.M.A. Can't Spank Him," said an Indianapolis News headline. And that started the rumor.

But it doesn't mean a thing. The blunt-talking director of the American College of Surgeons is in fact an A.M.A. member in good standing and has a 1953 membership card to prove it. So that, for whatever significance it may have, is that.

# **IGHATS Are Aghast**

A recent businessmen's luncheon in Cedar Rapids, Iowa, turned into a table-pounding tax-gripe session. Result: the start of a new movement known as IGHATS. (No, that's no

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typographic error. Spelled out, it means "I'm gonna holler about taxes.")

# Off the Pension Roll

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If you're a part-time company doctor, the Bureau of Internal Revenue no longer considers you an employe for Social Security purposes. A new ruling to this effect reverses a position held by the Government for fifteen years and challenged in the courts for the last four [see MEDICAL ECONOMICS, August, 1952, page 173]. Result: The front office has stopped taking a bite out of your check for old-age and unemployment benefits.

But suppose you want to make Social Security payments. In that case, you may still be able to do so if you can show that you're "sufficiently under company control as to hours and working conditions to be, in effect, an employe."

# Deduct for Health?

There's a chance that Federal employes will eventually pay their voluntary health insurance premiums through payroll deductions. Authorization for such an insurance stimulant is contained in a bill (S.2191) introduced recently by Senator Frank Carlson (R., Kan.).

Though Mr. Carlson himself is



Frank Carlson
Stimulant for health insurance?



Oliver P. Bolton

A poll gave him solid backing

# PANORAMA

forecasting no early action on his measure, two factors favor its passage: (1) Carlson's own personal popularity; (2) the fact that the bill has been referred to the Committee on Post Office and Civil Service, which Carlson heads.

# P.G. Work Via TV?

Can you picture yourself flicking a dial in your office and tuning in on a color-television medical post-graduate course, brought in directly over a pay-as-you-view closed circuit? This won't happen tomorrow, of course. But Smith, Kline & French, the pharmaceutical house that has pioneered medical TV, is looking into the possibilities and has hopes for teaching by video sometime in the future.

Main hurdles between you and that comfortable P.G. course: financing and, naturally, Government approval.

# New Health Plan Hit

One of the latest wrinkles in health insurance is the "semi-private" plan offered by Group Health Insurance, Inc., a carrier long active in the New York metropolitan area. G.H.I.'s new gimmick is this:

If your patient, regardless of his income, accepts semi-private hospital care, your *entire* fee is paid by G.H.I. in accordance with a prepared fee schedule.

Although this carrier claims to

offer subscribers a choice of 9,000 doctors, the Medical Society of the State of New York recently has disapproved its "semi-private" plan overwhelmingly. Main reason, according to a society spokesman:

"Since only 15 per cent of hospital patients occupy private beds, a situation could develop where participating doctors would be paid up to 85 per cent of their incomes on fee schedules that might or might not be under the medical profession's control. If that happened, the doctor would lose his right to establish for himself the fair value of his services."

# M.D. Census Hits Peak

America's steadily growing doctor population achieved a high of 214,-667 by the end of last year. The latest A.M.A. census of M.D.s in the U.S. and its territories is almost 3,-000 larger than the 1951 medical nose count and 5,600 greater than that of 1950. In the accompanying chart, statistics on pre-World War II doctors are contrasted with figures on their post-war colleagues. Most significant development in fourteen years: the trend toward Government service and toward posts in hospital, teaching, and research fields.

# What Makes T-Men Call?

If your income is \$25,000 or more, you can expect the Bureau of Internal Revenue to use the proverbial

fine-tooth comb in scrutinizing your income tax returns. "At a very minimum," says Tax Expert J. K. Lasser, "every other year [the bureau] will pull out your returns of two years for examination."

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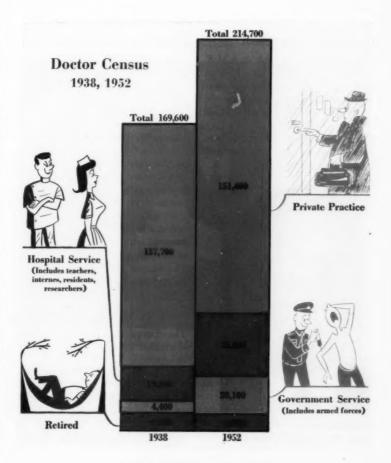
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And what, in particular, are the tax collectors looking for? According to Lasser, you're most likely to be challenged on one of these points:

¶ Your deductions for dependents; [MORE→



## PANORAMA

¶ The amounts you claim to have paid out for various professional expenses;

¶ Deductions for depreciation;

¶ What you claim as travel expenses; and

¶ Claims in connection with your partnership, if any.

# Veterans' Care Clash

Testifying in his new role as A.M.A. president-elect, Dr. Walter B. Martin recently told Congressmen where organized medicine stands on the issue of Veterans Administration hospital policy.

He said that in nearly all cases, doctors oppose free care for vet-



Walter B. Martin
'Time for a change in the V.A.'

erans with non-service-connected ailments. The exceptions: tuberculosis and mental disease, for those veterans who can't afford to pay for private care.

u

Taking a similar stand, Dr. William B. Walsh, president-elect of the Medical Veterans Society, told members of a House subcommittee about sixty veterans in one city who got free care despite the fact that they could well afford to pay. Among the sixty he listed: a judge, a state attorney general, and several doctors.

The subcommittee also heard from various veterans' organizations, including the American Legion, which is fighting the A.M.A. tooth and nail on the veterans issue. Charged a Legion spokesman: The doctors "suck the flesh and blood of veterans and then turn them over to the V.A."

Even so, the legionnaire conceded, it might be a good idea to ask more penetrating questions of veterans who seek free hospital care. The outlook, though, is for no early change in V.A. policy.

# Cultists March On

The chiropractors have won several skirmishes lately in their battle for recognition.

In New Jersey, for example, the State Board of Medical Examiners had long judged the qualifications of chiropractors in terms of medical standards; and, as a result, few of the cultists had succeeded in beThre

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coming licensed. But now Governor Alfred E. Driscoll has signed a law that tells the board, in effect, to use a separate yardstick for measuring a chiropractor's ability.

Medical men aren't the only ones unhappy about the new law. The New Jersey chiropractors' society professes displeasure, too, because M.D.s remain in control of the examining board. The cultists say they'll be satisfied with nothing short of a separate board of chiropractic examiners.

# **Insurers Give to Medical Education**



Three leaders in the life insurance industry present a trio of \$50,000 checks to the National Fund for Medical Education. Left to right are Devereux C. Josephs, president of New York Life; Ray D. Murphy, president of Equitable Life; and Leroy A. Lincoln, board chairman of Metropolitan Life. Accepting the \$150,000 for the fund is Peter M. Fraser, president of Connecticut Mutual Life and chairman of the fund's life insurance division. Through contributions such as these, the fund has been able to split a melon of \$1.94 million among the nation's medical schools, just in time for the start of the fall semester.

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# Dramamine



# in Vertigo

The remarkable relief afforded by Dramamine in motion sickness has led to studies of its possible value in allied conditions.

Dramamine apparently depresses hyperstimulation of the vestibular apparatus. Thus it is an effective means of relieving the nausea and vertigo which characterize dysfunctions of the middle ear.

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### MOTION SICKNESS

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VESTIBULAR DYSFUNCTION associated with streptomycin therapy

### **VERTIGO** in

Ménière's syndrome hypertensive disease fenestration procedures labyrinthitis radiation sickness



SEARLE

Research in the Service of Medicine



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# 'MIEILOZZIETS'

METHYLCELLULOSE WAFERS\*



Patent applied for

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'Melozets' look and taste like graham crackers. Each wafer contains 1.5 Gm. of methylcellulose and supplies approximately 30 calories. Eating 'Melozets' gives a sense of satisfying fullness.

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**SUPPLIED:** By pharmacists in ½-lb. boxes of about 25.

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For a pad of sheets, each with 42 different 'Melozets' reducing menus, and a sample of 'Melozets', drop a note on your prescription blank to Professional Service Dept., Sharp & Dohme, West Point, Pennsylvania.



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# AFTER FORMULA DAYS ARE OVER, TOO!

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Pet Milk is complete in the essential food values of milk . . . helps develop strong bones and sound teeth . . . and helps babies grow. Infants who have thrived on Pet Milk are ac-

customed to this good milk . . .

and readily accept it, diluted with water, as a delicious beverage.

At the same time, parents find that Pet Milk is just as easy to use as other forms of milk-no more bottles, no more sterilizing, no more fuss.

And Pet Milk, the original evaporated milk, costs less than any other form of whole milk-that means big savings on food bills in these days of high living costs.

So recommend against changing the milk they thrive on. Urge young mothers to use Pet Milk after weaning, too.

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# they've heard the call for Vi-Daylin°

(Homogenized Mixture of Vitamins A, B<sub>1</sub>, B<sub>2</sub>, B<sub>12</sub>, C, D and Nicotinamide, Abbott)

Better stand back when Mom sounds the call for VI-DAYLIN. Kids really scoot for this delicious multivitamin's honey-yellow shine, fresh citrus flavor and lemon-candy goodness.

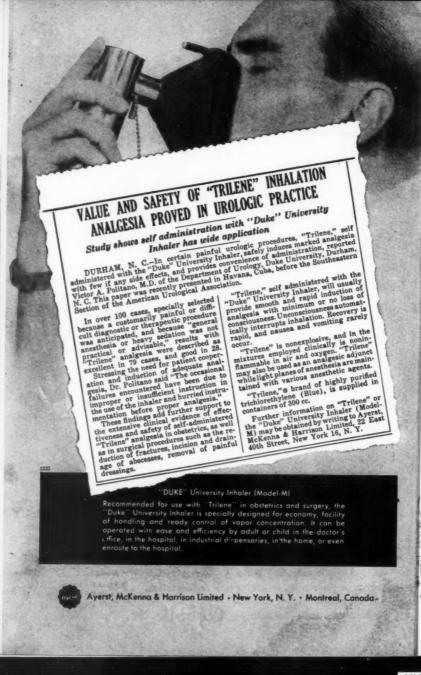
With seven important vitamins—including 3 mcg. of body-building B<sub>12</sub>—in every lip-smacking spoonful, more and more physicians are calling for Vi-Daylin for their little patients.

For children up to 12, Mom can serve the daily dose right from the spoon. For infants, she can mix it in milk, cereals or juices. VI-DAYLIN needs no pre-mixing, no droppers, no refrigeration. At all pharmacies in 90 cc., 8-fluidounce and 1-pint bottles.

Each 5-cc. teaspoonful of VI-DAYLIN contains:

	Vitamin A 3000 U.S.P. units
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	Thiamine Hydrechleride1.5 mg.
	Ribeflavin1.2 mg.
	Ascerbic Acid
•	Vitamin B <sub>12</sub> Activity3 meg. (by microbiological assay)
	Nicetinamide10 mg.

1-208A



2/12

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# speaking of allergy, let's get down to cases

The documented record—more than 900 reports—shows literally thousands of allergic patients relieved of symptoms by Pyribenzamine. Relief has been prompt and prolonged, with extremely low incidence of sedation or other side reactions.

On the basis of published evidence, no other antihistamine combines greater

clinical benefit with greater freedom from side effects. Supplied: Pyribenzamine hydrochloride (tripelennamine hydrochloride Ciba) 50 mg. (scored) tablets, bottles of 100 and 1000.

# Pyribenzamine®



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# **Antipruritic Scoreboard**

ineffective	sensitizing	and safe
X',2		Witness Street
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X	X	
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	AND AND ADDRESS OF THE PARTY OF	X <sup>1,2</sup>

Calmitol avoids the therapeutic pitfall of sensitization. Safe and effective, the specific antipruritic ingredients of Calmitol—camphorated chloral, hyoscyamine oleate and menthol—raise the threshold of skin receptors and sensory nerve endings, stopping pruritus at the point of origin.

Lobitz, W. C., Jr., and Jillson, O. F.: Postgrad. Med. 12:2, 1952.
 Goodman, H.: J.A.M.A. 129:707, 1945.

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 Underwood, G. B., et al.: J.A.M.A. 130:240, 1946.

4. Lubowe, I. I.: New York State J. Med. 50:1743, 1950.

5. Nomland, R.: Postgrad, Med. 11:412, 1952.



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provides safer, higher plasma salicylate levels for marked relief of pain

protects against vitamin C depletion due to urinary loss

provides anti-hemorrhagic protection during prolonged salicylate therapy

\*The Therapeutic Difference is 50 mg. of Ascorbic Acid in each tablet + sodium salicylate 0.3 Gm. + sodium para-aminobenzoate 0.3 Gm.

Armyl three additional dosage formulations for your choice

- 1 Armyl with 1/2 grain Phenobarbital
- 2 Armyl Sodium-Free
- 3 Armyl Sodium-Free with 1/8 grain Phenobarbital

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to control even stubborn cases of . . .







dry eczema

dermatitis

plant, allergic, chemical

pruritus

ani, vulvae, etc.

fissured nipples

diaper rash

chafing, heat rash, excoriation

external ulcers

vascular, varicose, decubitus

sunburn

and other burns

and other dermatoses

# panthoderm cream

the **first** and **only** topical therapy to contain pantothenylol (analog of pantothenic acid)

A surprising number of otherwise intractable skin conditions are amenable to treatment with Panthoderm Greem, 1-3 in hundreds of ulcerative and pyogenic dermatological cases "a majority healed and many showed various degrees of improvement "1

(Panthoderm Cream) show nical evidence of epithelizing stimulation, of an antipruritie offect, and of an antibacterial offect...

In seme cases the result was obtained with a marked efficiency not obtained by other topical remedies . . . No ovidence of sensitization . . . was encountered."1

"This proparation

eases pain and itching

allays inflammation

stimulates granulation

> speeds healing

non-sensitizing

Panthoderm Cream is soothing, bland, non-irritating ... clean, snow-white, non-staining; water-miscible, spreads readily; easily removed without injury to granulating tissues.

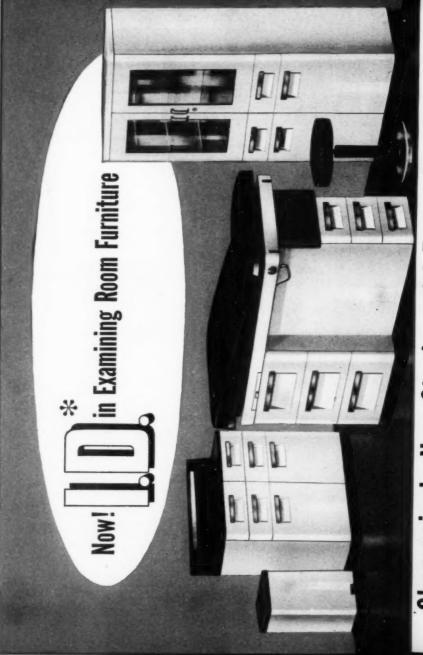
> 2 oz. anti 1 ib. jere 1 oz. tubes.



- 1. Kline, P. R., and Caldwell, A.: New York St. J. M. May 2, 1982.
- 2. Combos, F. C., and Zuckerman, R.: J. Invest. Dormat. 16:379, 1951,
- 3. Kline, P. R.: Current Hows in Derm. & Syph., May 1952.

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# Shampaine's New Steelux with Integrated Design



New narrow width permits standor sitting much closer to patient, and pedestal may be strad-dled for GU and GYN examination. Streamlined pedestal base



tractable, fully concealed. Stirrup rods are released by a push-but-Heel stirrups are completely reton, swing up into locked position. Push-button concealed stirrups



ull-out leg extension

Sloping top Newly contoured

stal end. When lifted, it locks into firm position, level with table top. Adjustable horizontally, and pad-ded and covered as table top. Pulls out, drawer style, from pedetwo-piece top provides extra comfort for patient. covered with acid-and-stain-

and covered with acid-ang-sta

is Integrated Design. The mechanical features needed for examination and treatment—stirrups, leg rest, foot step and many more—are designed as an integral part of the whole, rather than being just "attached." Beauty as well as practicality is added to the furniture. Result: a new level of efficiency combined with the utmost in patient comfort and maximum convenience to the physician. In addition to such appearance "extras" as rounded corners and recessed drawer pulls, Steelux features A TRULY GREAT CHOICE OF COLOR-18 enamel tones coordinated with 8 contrasting or harmonizing shades of upholstery fabricsl

Manufacturers of a Complete Line of Physicians' and **Hospital Equipment** 

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Please send me complete information on Shampaine's new Steelux Examining Room Furniture.

Name

My dealer is Street



for caloric boost without gastric burden ...when weight gain is the objective

# EDIOL

[ ORAL FAT EMULSION SCHENLEY ]

Just 2 tablespoonfuls of EDIOL\* oral fat emulsion q.i.d. add 600 extra calories to the daily diet without increasing bulk intake or blunting the appetite for essential foods. This EDIOL regimen is the caloric equivalent of:

6 servings of macaroni and cheese, or 1 dozen Parker House rolls, or 12 pats of butter, or 8 boiled eggs, or 6 baked potatoes, or 9% slices of bread

EDIOL is an exceptionally palatable, creamy emulsion of vegetable oil (50%) and sucrose (12½%). The unusually fine particle size of EDIOL (average, 1 micron) favors ease of digestion, rapid assimilation. For children, or when fat tolerance is a problem, small initial dosage may be prescribed, then increased to the level of individual tolerance.

Available through all pharmacies, in bottles of 16 fl.oz.

# schenley

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# Sidelights

Your best bet in group

malpractice protection • Doctors pool their charitable dona-

tions • When a prepayment plan seeks publicity

# **Unethical Advertising**

Our news pages this month tell of a resolution, passed recently by the Kings County (N.Y.) medical society, that would, if implemented, add to the restrictions that the A.M.A. code places on physicians' advertising. The resolution reads in part:

"Any medical care plan... which advertises for subscribers and directs such subcribers to a restricted panel of physicians is advertising for the benefit of the physicians involved."

If it does nothing else, the Brooklyn resolution should set doctors to thinking about an extremely pertinent ethical question: When a group-prepayment plan (e.g., Permanente, H.I.P.) advertises, is it advertising for the benefit of the program—or for the benefit of the physicians on its closed panel?

Court decisions in some states— California, for example—seem to indicate that a closed-panel insurance plan has as much legal right to advertise as does a plan like Blue Shield, in which all qualified doctors may participate if they want to.

But legal precedent and medical

ethics don't always agree. Personally, we feel that some group prepayment plans are guilty of unethical advertising, while others are not.

How to separate the good from the bad? Simply by testing each plan with these two questions:

 Does a broad cross-section of doctors in the area participate in the plan?

2. Is it possible—and practicable—for any doctor who wants to join the plan to do so?

If a plan can answer "yes" to both questions, there may well be no question of illegal advertising, it seems to us. Why not? Because any advertising of such a plan will tend to boost the stock of most doctors in the area—not just of a minority.

# Charity Headache

A colleague of ours had just finished dinner the other night when the phone rang. Answering it, he was greeted by a sugary-sounding voice, announcing that this was Mr. So-and-So representing Camp Po-Go-Stic for Underprivileged Boys.

The man said that a local news-

### SIDELIGHTS

paper had agreed to make a "sizable" donation to the camp for every subscriber Mr. So-and-So could recruit. So all our friend had to do was to take the paper for twenty-six weeks and he'd be helping rescue a deserving youngster from a lifetime of delinquency.

Unfortunately, the physician had once tried reading the paper in question and hadn't liked it at all. But he was perfectly willing to do his bit; so he said he might make the camp a cash donation.

That wouldn't do at all, he was told; Mr. So-and-So was only taking orders for the special newspaper

"But I don't want the paper," insisted the doctor.

Finally the voice dropped its sugar coating. "Of course, Doctor," it said, with open sarcasm, "I realize that it's expecting a lot of a man in your position to help a boy from the other side of the tracks."

Our friend hung up. When we ran into him the next day, he was muttering something about "the nerve of those goddam do-gooders."

"What am I supposed to do, anyway?" he asked. "Apparently I should give to one and all, sight unseen-and on their terms. Nuts! I want to contribute my share; but few of us have enough money to support all the charity drives in town; and I certainly haven't the time to try to separate the worthy ones from the phonies." [MORE→



# PROMPT RELIEF

FROM SURFACE PAIN AND ITCHING Via 20% Dissolved Benzocaine

Clinical studies show nothing relieves surface pain and itching like Americaine . . . because only Americaine contains 20% dissolved benzocaine . . . the first time such high concentration has been achieved. Shown to be more effective1, quicker acting2, longer lasting3, least toxic4.

- Tainter, M. L. & Winter, L.: Anesth. 5:470
   White, C. & Madura, J.: Postgr. Med., June, 1951
   Schmitz, H. E. et al: West. J. Surg. & Gyn., 59:117
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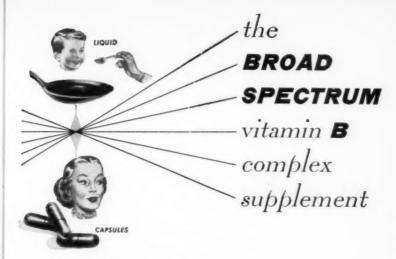
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# MEJALIN

For more complete effectiveness in vitamin B complex supplementation, Mejalin supplies all eleven of the identified B vitamins in well balanced amounts. Liver is added for its contribution of other B vitamins. Iron is included since B complex-deficient diets are often iron-deficient also.

This broad spectrum supplement is useful in such conditions as childhood anorexia, stress periods, e.g., adolescence and pregnancy, prolonged anti-biotic therapy, restricted diets, convalescence and liver disease, and in many other instances where B complex deficiency is present or may develop.

Mejalin is supplied in two exceptionally pleasant dosage forms: Liquid—infants and children like the appetizing candylike flavor; Capsules—usually preferred by adolescents and adults.

Each teaspoon (5 cc.) of Mejalin Liquid and each Mejalin Capsule supplies:

Thiamine hydrochloride	.1 mg.
Riboflavin	.1 mg
Nieclnemide	10 mg.
Pyridoxine hydrochloride0	1.2 mg.
Pantothenic acid*	
Choline	
Inositol	
Vitamin B <sub>12</sub> (crystalline)0.3	
Folic acid	
Biotin	02 mg.
Para-aminobenzoic acid0	
Liver fraction*3	
Iron® (ferrous sulfate)	.5 ma.

<sup>6</sup>Mejalin Liquid contains panthenal and soluble liver fraction N.F.; Mejalin Capsules contain calcium pantothenate and desiccated liver N.F.



# MEJALIN

MEAD JOHNSON & COMPANY Evansville 21, Ind., U.S.A.



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introducing

# Contain \*\*

for topical anti-inflammatory therapy of dermatitis

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A completely new approach to the management of dermatitis has been achieved. Upjohn scientists have developed Cortef Acetate Ointment for the application of the most active adrenal steroid -compound F-into affected skin layers.

Up to now, the conventional treatment of dermatitis has been primarily empirical and symptomatic (e.g., calamine for pruritus). Cortef Acetate Ointment offers a new approach through its anti-inflammatory effect. It permits the full utilization of the anti-inflammatory activity of compound F (hydrocortisone) at the tissue level without producing systemic effects.

Unlike cortisone, compound F (hydrocortisone) is effective on the skin. Results are often immediate and striking: lesions turn pale and flat; erythema. edema, and infiltration subside. And in the many instances where atopic dermatitis is self-limited, quick suppression of symptoms with Cortef Acetate Ointment may prove tantamount to cure.

Even cases refractory for years or decades to other forms of treatment have been reported yielding to the new hormonal therapy with Cortef Acetate Ointment.

# tate ointment Upjohn



RAND OF HYDROCORTISONE ACETATE)

# SUPPLIED:

Cortef Acetate Ointment is available in 5 Gm. tubes in two strengths-2.5% concentration (25 mg. per Gm.) for initial therapy in more serious cases of dermatitis, and 1.0% concentration (10 mg. per Gm.) for milder cases and for maintenance therapy.

# ADMINISTERED:

A small amount is rubbed gently into the involved area one to three times a day until definite evidence of improvement is observed. The frequency of application may then be reduced to once a day or less, depending upon the results obtained.

\*Trademark

A product of



for medicine . . . produced with care . . . designed for health

THE UPJOHN COMPANY, KALAMAZOO, MICHIGAN

### SIDELIGHTS

At the time we couldn't do much more for our friend than to nod in agreement. But we're now going to make sure he sees an article in this issue, describing how Santa Monica, Calif., doctors solved this very problem. Three-quarters of the physicians in Santa Monica have set up an organization that distributes their charity money—and distributes it where it does the most good.

Sounds like a fine idea to us. And we suspect that many charity-pressed doctors will agree.

# **County Coverage**

Maybe there'll come a day when organized medicine will provide malpractice insurance coverage for its members. The possibility is raised, at any rate, in our editorial pages this month. But if it's coming at all, that day is certainly a long way off.

Which leaves the average doctor with a still unsolved problem: How -and where-can he get reasonably priced malpractice protection now?

One answer comes from local medical societies in many areas. In conjunction with private carriers, they're operating group professional-liability plans; and a number of physicians are depending more and more on such plans for coverage.

We're all for the idea. But we've found that the success of any such plan for the individual doctor may depend on how he interprets the word "local."

Experience has shown that a mal-

practice policy written on a county basis tends to give doctors a better deal than one written on a state or national basis. This holds true for several reasons:

In the first place, a truly local plan is obviously likely to give more personal service than one that may be located at some distance from the individual doctor. Then, too, claims prevention activity can usually be handled most effectively through the county medical society, with its smaller membership.

Even more important, the groupmalpractice plan written on a county basis gives the careful M.D. a sense of participation that no state or national program could provide. As one of a *limited* number of participants, he can more readily appreciate how his carefulness will pay dividends in the form of lower rates.

The few attempts that have been made to insure doctors on a national scale (for example, through a specialty society) have been conspicuous failures. It's difficult in such cases to enroll a high enough percentage of doctors to make for a fair selection of risk. One specialty society that tried to run its own plan never managed to enroll more than 30 per cent of its membership; as a result, the insurance carrier finally discontinued the policy.

So if you're searching for a groupmalpractice insurance plan, why not look for one right at your doorstep? You may find exactly what you want at the county-society level.



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# You have a big place in your practice for a good tonic

The convalescent, the overworked, the constitutionally delicate, the neurasthenic, the chronically fatigued, the anorectic and the aged . . . these are the patients—neither seriously ill, nor yet entirely well—who often respond dramatically to the administration of these outstanding tonics.

# Eskay's Neuro Phosphates \* a palatable and effective tonic

a palatable and effective tonic

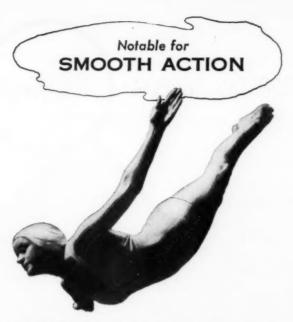


the formula of 'Neuro Phosphates' plus Vitamin B1

Prescribed so widely because they work

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HALEY'S M-O has long been relied on for smooth, gentle action in relieving constipation and accompanying gastric acidity. This pleasant tasting emulsion combines the laxative-antacid properties of Phillips' Milk of Magnesia with the lubricating qualities of pure mineral oil



Because the minute oil globules are thoroughly distributed and mixed with the contents of the lower bowel, evacuation is bland, soft and thorough. There is no griping or discomfort and oil leakage is obviated.

Evidence of the demulcent character of Haley's M-O is its frequent professional recommendation when constipation is concurrent with pregnancy or hemorrhoidal conditions.

#### DOSAGE:

1 to 2 tablespoonfuls before retiring.

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RESEARCH

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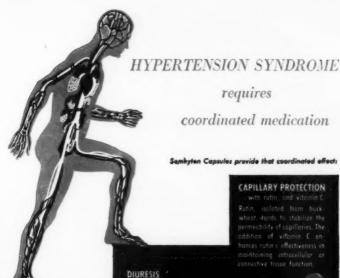


The makers of Camels never cease their efforts to maintain and to improve the standards of quality that distinguish America's most popular cigarette.

The plant shown above, which was opened this year, is a \$2,000,000 addition to Camel's research facilities.



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#### VASODILATION

Produces slow full of systolic

#### SEDATION

with phenobarbital: Long-



#### Mannitol Hexanitrate

. . . . . ½ gr. (30 mg.) Theophylline . . 11/2 gr. (0.1 Gm.) **Phenobarbital** 

. . . . . . ¼ gr. (15 mg.)

Ascorbic Acid



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And so with the other social whirlers and faddist dieters, the hurriers and worriers, the smokers and topers. Along with a new dietary they need DAYALETS, the fishless, burpless multivitamins. No allergies due to fish oils—the vitamin A is synthetic. Bottles of 50, 100 and 250.

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represents:
Vitamin A. 10,000 U.S.P. units
Vitamin D. 1000 U.S.P. units
Thiamine Mononitrate. 5 mg.
Riboffavin. 5 mg.
Ricoffavin. 25 mg.
Ricoffavin. 25 mg.
Vitamin 812. 1 mg.
Vitamin 812. 5 mg.
Fantothersk Acid. 5 mg.

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Whenever you find <a href="mailto:constipation">constipation</a>
with attendant symptoms of <a href="mailto:biliary dysfunction">biliary dysfunction</a>
(as so often is the case) you will find appropriate therapy in <a href="mailto:zilatone-tablets">Zilatone tablets</a>



BILE SALTS . . . to improve biliary function
MILD LAXATIVES . . . to relieve constipation
DIGESTANTS . . . to combat dyspeptic distress

Available at all pharmacies in boxes of 20, 40, and 80 tablets; also in bottles of 500 and 1000

Generous trial samples to physicians on request

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### in ARTHRITIS and al

Like other potent therapeutic agents, Bi 13201 iorx may sometimes produce undesirable side actions. To achieve optimal results with minimal risk of toxicity certain simple precautions are recommended:

Careful Selection of Patients excluding the senile and those with a history of peptic ulcer, drug allergy or cardiac disease.

Moderate Dosage individualized for each patient at the lowest level required to produce and maintain therapeutic benefit.

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For detailed information physicians are utsed to send for the brochure "Essential Clinical Data on BULYZOLINIX."

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(brand of phenylbutazone)

#### effective and potent therapeutic agent

Experience in several hundred thousand cases has now completely confirmed the therapeutic potency of the new antiarthritic agent, BUTAZOLIDIN. This entirely new synthetic, unrelated to the steroid hormones, affords these distinctive advantages:

- Broad Spectrum of Action including virtually all forms of arthritis and many other painful musculoskeletal disorders.
  - Great Therapeutic Effectiveness manifested by relief of pain and functional improvement in the majority of cases.
- No Development of Tolerance leading to escape from control.
- Simple Oral Administration.

Indications include gout, spondylitis, rheumatoid arthritis, osteoarthritis, and psoriatic arthritis as well as fibrositis, bursitis, and other periarticular disorders.

BUTAZOLIDIN<sup>®</sup> (brand of phenylbutazone)
Tablets of 100 and 200 mg.



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Dyspeptic

antacids neutralize acidity but stop protein digestion





neutralizes acidity and maintains protein digestion



Al-Caroid contains effective antacid ingredients, plus the potent proteolytic enzyme, "Caroid,"\*

Al-Caroid relieves gastric acidity promptly without retarding gastric digestion.

Al-Caroid speeds both the digestion and assimilation of needed proteins.

**TABLETS** in bottles of 20, 50, 100, 500 and 1000

**POWDER** in packages of 2 oz., 4 oz., and 1 lb.

\*"Caroid" is a potent proteolytic enzyme from the tropical tree, Carica Papaya. It offers added benefits over animal enzymes or ferments because "Caroid" functions in acid as well as alkaline media.

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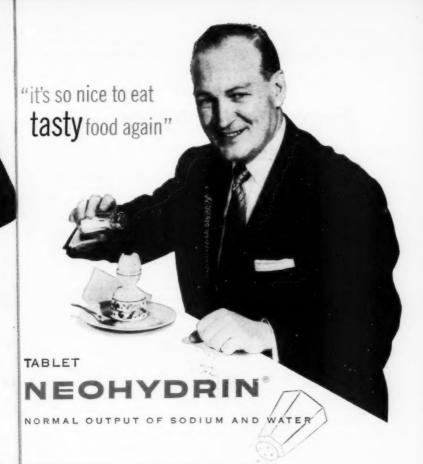
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PRESCRIBE NEOHYDRIN whenever there is retention of sodium and water except in acute nephritis and in intractable oliguric states. You can balance the output of salt and water against a more physiologic intake by individualizing dosage. From one to six tablets a day, as needed.

PRESCRIBE NEOHYDRIN in bottles of 50 tablets. There are 18.3 mg.

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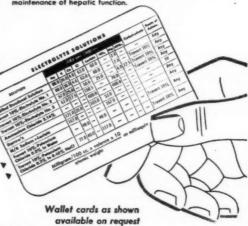
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all the advantages
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replacement of

electrolytes, and correction of acidosis and alkalosis

\* Travert 10% Solutions provide:
twice as many calories as 5% dextrose,
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# In the Treatment of NEURITIS

(Sciatic-Intercostal-Facial)

"...patients responded with complete relief of pain"\*

# WITH PROTAMIDE



Richard T. Smith, M.D., in a currently published paper, "Treatment of Neuritis with Protamide" reports: 84 patients of 104 had complete relief of pain in sciatic, intercostal and facial neuritis with one daily injection of Protamide for five or ten days.

"... 49 were discharged as cured after five days of therapy."

No intolerance to Protamide, systemic or local was found in the 125 patients (104 plus 21 controls). Two qualifications for practical application of this study are:

- 1. The elimination of cases due to mechanical pressure.
- 2. Early treatment after onset.

Your prescription blank marked NEURITIS REPRINT will bring literature.

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NEWS ABOUT A BAUER & BLACK PRODUCT

# Shouldn't an elastic bandage let you control the pressure?

When you accelerate your automobile, you tap its reserve power. The more power, the smoother the acceleration. The same with elastic bandages. Reserve elastic power means smoother control—even at mild pressures.

That's why it's so easy to control pressure with Tensor. Tensor, as the photo shows, is twice as elastic as old-style bandage—stretches farther and snaps back all the way. And no wonder—Tensor is woven with live rubber threads—not just cotton.

With Tensor you apply low pressure as easily as higher pressure.

You get uniform pressure over all bandaged areas.

There's less danger of hyperconstriction of blood vessels—more comfort, more mobility for the patient.

And you don't have to adjust Tensor as swelling goes up or down—it adjusts itself.

You, doctor, not the bandage, control the pressure—when it's Tensor.

# TENSOR

ELASTIC BANDAGE
Woven with live rubber threads

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# OYSMENORRHEA

Estrogen and androgen go together
like "compass and pen"
to provide a dual approach
for maximum efficiency
in dysmenorrhea.
Many clinicians feel
that these two steroids,
together, as combined in
"Premarin" with Methyltestosterone,
are more effective
than either one alone
in producing relief of pain
by suppressing ovulation.
Excellent results have been reported
from such therapy.

#### "PREMARIN" with METHYLTESTOSTERONE

for combined estrogen-androgen therapy



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It's more than her work. It's a problem you encounter often—iron-deficiency anemia with the usual nutritional deficiencies.

By prescribing one IBEROL tablet t.i.d., you assure her of a therapeutic dose of iron, seven B complex factors including B<sub>12</sub>, standardized stomach-liver digest and ascorbic acid.

There's no unpleasant liver odor or taste. Each triple-coated, compressed tablet has an outer sugar coating to mask the iron.

For pregnancy, old age or convalescence, one or two IBEROL tablets daily are usually enough. In pernicious anemia, IBEROL may be used as a supplemental hematinic. Available in bottles of 100, 500 and 1000.

#### THREE IBEROL TABLETS,

the daily therapeutic dose, supply:

Plus these nutritional constituents:

	Plus these nutritional constituents:		
	Thiamine Mononitrate (6 times MDR*)	6	ms
	Riboflavin (3 times MDR*)	6	mg
	Nicotinamide (2 times RDA†)	30	mg
	Ascorbic Acid (5 times MDR*) 1	50	mg
	Pyridoxine Hydrochloride		
	Pantothenic Acid		
-	-Vitamin B <sub>12</sub> 30	9 8	neg
	Folic Acid	.6	mg
	Stomach-Liver Digest 1.	5 (	Gm
	434TND Minimum Delly Requirement		

†RDA —Recommended Daily Dietary Allowance

# Prescribe IBEROL®

(fron, B<sub>12</sub>, Folic Acid, Stomach-Liver Digest, with other Vitamins, Abbott)

7-120

## Letters

Should doctors be bankers? • Sur-

geons versus G.P.s • Loans for residency • Handling unruly children • Labor's demands come under fire • Obstetrical charges • Stock market pay-off • How to save money

#### **Buy Bonds!**

Sirs: Shame on you! Your answer to the question "Can you suggest a good system for saving money?" should have been *Buy a savings* bond a month! Your bank will gladly get you whatever denomination you specify, and will charge the purchase to your account.

> Herman Goodman, M.D. New York, N.Y.

#### Loans for Patients

Sirs: Few articles have been as disturbing to me as the one in your June issue entitled, "Loan Plans Spur Patient Pay."

We doctors are worried about the deterioration in the affection and respect in which the public once held the physician. This happy relationship during past generations was due to the fact that the doctor was dedicated to helping sick people. If he didn't have any wonder drugs, at least he stood by with selfless vigilance. He was a professional man, not a banker. His eye was on the pa-

tient's health, not on the patient's credit rating.

If the patient is a responsible citizen, the doctor can depend on the collection methods we've used for decades. To be sure, these methods result in some uncollectible accounts. But most of the people concerned are deadbeats who couldn't get a bank loan anyway.

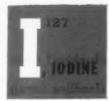
Most accounts that could justify a bank loan are collectible by direct methods. The exceptions are too few to jeopardize the precious fabric of the doctor-patient relationship.

M.D., Virginia

#### Dividing Fees

Sirs: The views expressed by Dr. Caldwell in your June issue ["How We Apportion Fees Ethically"] are probably acceptable to most surgeons—even though the heads of the A.C.S. may disagree.

If a surgeon performed only 200 majors a year, and collected the average fees charged in my community, he'd gross over \$50,000 annually. A G.P. here who gets no income



#### The TINY GIANT

**Element of Biological Necessity** 

# Organidin

IODINE ORGANICALLY COMBINED

THE UNFOLDING SECRETS OF METABOLISM REVEAL MAN'S DEPENDENCE UPON IODINE AS THE "ELEMENT OF BIOLOGICAL NECESSITY" .

IODINE poverty and mild hypothyroidism appear to be part of the aging process after the 40th year. The most prominent complaints of this age group are chronic fatigue, poor memory, and sleeplessness.

IODINE medication in these patients with beginning thyroid inadequacy may be of real benefit in restoring mental alertness and physical vigor.

Evidence is accumulating that mild iodine deficiency and hypothyroidism may produce cumulative harm in contributing to hypercholesterolemia, myocardial damage and mental regression. Judicious use of IoDINE may well prove to be an important preventive and corrective measure after the 40th year.

ORGANIDIN WAMPOLE is a unique, well-tolerated, standardized iodine preparation which is the result of original research in the laboratories of Henry K. Wampole & Co., Inc. Consistently satisfactory therapeutic results have established Organidin as the Iodine preparation of choice among the vast majority of physicians.

Supplied: 30-cc. bottles with dropper. Literature and sample on request.

#### WAMPOLE LABORATORIES

HENRY K. WAMPOLE CO., INCORPORATED • PHILADELPHIA 23, PA. Crampton, C. W., The Merck Report, 57:26 (1948). Kimble, S. T., and Steiglitz, E. J., Geriarire 7:20 (1952)

#### AVAILABLE IN A

New Dosage FORM

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# Organidin

TABLETS

IODINE ORGANICALLY COMBINED

Each Tablet Equivalent to 10 Minims of Solution, 1/4 gr. of Iodine.

#### DOSAGE RECOMMENDATIONS

- Thyrotoxicosis (preoperative and postoperative Treatment): One tablet one to three times daily.
- Arteriosclerosis, Angina Pectoris, Essential Hypertension: One to three tablets, three times daily.
- 3. Rheumatic affections, asthma, bronchitis, the Common Cold, and other infections: One to three tablets, three times daily.

Supplied: Bottles of 100 tablets

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from surgical fees would work much longer hours and have difficulty grossing even \$30,000.

Thus, over a period of twenty-five years the difference in these two men's gross earnings would be about \$500,000. Does anyone actually believe that the work of the surgeon is worth that much more?

Incidentally, though I may sound like a disgruntled G.P., I'm a surgeon myself.

M.D., California

#### **Borrowing Money**

SIRS: One of your June Questions came from an interne who needed to borrow money to take care of his family next year during his residency. You asked your readers for suggestions. Here's mine:

According to a recent article in Your Life magazine, Mr. John Marvin Yost, First National Bank, Pikesville, Kentucky, lends money to worthy students.

> M. K. Hartzell, M.D. Eugene, Ore.

Sirs: I suggest that the interne enter general practice until he saves enough money to see him through a residency. (Such general practice will be invaluable to him in his specialty.) Barring that, why can't his wife take a job until he's in practice?

Hewitt W. Smith, M.D. Harrington, Del.

Sirs: Why don't hospitals establish loan funds and ask staff members to make contributions? A resident could then apply for a loan, to be repaid out of his income when he starts practice. Such a plan would benefit the hospitals, too, by making it easier for them to fill residencies.

William J. Yonker, M.D. Delray Beach, Fla.

Sins: From time to time it's been suggested that community banks make loans to internes or residents, with hospitals or older doctors signing the notes. Medical schools or medical societies might also make funds available to young doctors.

A life insurance policy, with the lending agency as beneficiary, would cover the possibility that the young man might die before the loan is repaid.

M.D., Massachusetts

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#### **Professional Courtesy**

Sirs: Some of your readers may be interested in my solution to the recently discussed problem of professional courtesy. When an M.D. delivered our latest child, I sent \$100 in his name to the American Medical Education Foundation. He received an acknowledgment, and all concerned were happy.

M.D., Massachusetts

#### Hellions

Sirs: I've been interested in your recent articles on how physicians can handle obstreperous children. Maybe this wouldn't be such a problem if they did a better job with their own kids.

My boss has a little darling who

Upjohn

cortisone for inflammation, neomycin for infection:

Each gram contains:

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Cortisone Acetate . . . . 15 mg.

Neomycin Sulfate . . . . 5 mg.

(equivalent to 3.5 mg. neomycin base)

Available in 1 drachm tubes with applicator tip

The Upjohn Company, Kalamazoo, Michigan



Neosone Trademark OPHTHALMIC OINTMENT

#### LETTERS

regularly invades the reception room, whether or not there are patients waiting. He throws the neatly arranged magazines on the floor, jams the keys on my typewriter, and wipes his feet on the upholstery.

Let doctors teach their own children to behave properly. Then other parents may follow their example.

Doctor's Aide, Kansas

eyes to these trends. If we accept prepayment plans that provide complete coverage for all types of illness at specified rates-contracts which prevent the doctor from making any direct charge to the patient -aren't we accepting socialization? John M. Hoffman, M.D.

It's time we doctors opened our

McMinnville, Ore.

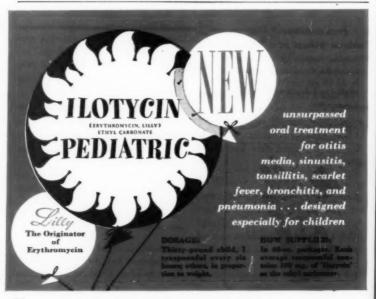
#### 'Complete' Security

SIRS: According to your June issue, "Labor Demands 'Complete' Health Security."

Oh, it does, does it! Prepayment plans that pay for everything, I suppose-even drugs and appliances. Isn't that a cozy thought? No doubt even the dog would be covered!

Sirs: Labor accepts without question the hypothesis that any illness expense is exorbitant-hence, an injustice to the workingman. So it concludes that all medical care should be free.

If a tree is blown down on your roof, do the carpenters and lumbersupply houses forget their bills? If



for peptic ulcer patients 8 hours' relief from a single dose

# PRANTAL RA

TABLETS

first repeat action anticholinergic

Four to 6 hours' relief from 50 mg.



Then another 4 to 6 hours' relief from 50 mg. inner dose

less frequent dosage uninterrupted night rest greater freedom from side effects

PRANTAL\*

3 forms
for more
flexible therapy

PRANTAL Repeat Action Tablets, 100 mg.
Dosage: One or two tablets every eight hours.
PRANTAL Tablets (plain), 100 mg., scored.
Dosage: One or two tablets every six hours.
PRANTAL Injection (subcutaneous or intramuscular), 25 mg. per cc., 10 cc. vials.
Dosage: 0.5 mg. per Kg. of body weight every six hours.

T. M. Brand of diphenmerbanil methylsulfate

Schering corporation . Bloomfield, New Jersey

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Clinically proven more effective than salicylates alone—and remarkably free from toxic effects, even on prolonged administration. 'Smith, R. T.: J. Lancet 70:192, 1950

A. H. ROBINS CO., INC. . Richmond 20, Valibical

Pabalate-Sodium Free is equally effective—
for use when sodium intake is restricted,
as in certain circulatory diseases, and
for concurrent administration with
ACTH and cortisone.

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Each yellow enteric-coated Tablet provides 0.3 Gm. (5 gr.) sodium salicylate U.S.P., and 0.3 Gm. (5 gr.) para-aminobenzoic acid (as the sodium salt).

Verthical Pharmaceuticals of Merit since 1878

Each Persian rose enteric-coated Tablet provides 0.3 Gm. (5 gr.) ammonium salicylate, and 0.3 Gm. (5 gr.) para-amino-benzoic acid (as the potassium salt).

ontains 50 mg. ascorbic acid.

is cost to patient.

Or, when sodium intake is restricted

labalate-Sodium Free

#### LETTERS

your car skids and is demolished, does the auto dealer replace it for

These examples aren't far-fetched; they're just everyday misfortunes. And while they don't happen every day to everyone, we carry insurance against the possibility that they may happen to us. That's why many people have health insurance, too.

Let those who complain about the cost of medical care take out such insurance. In Michigan complete coverage by Blue Cross and Blue Shield costs only about as much as a pack of cigarettes a day.

M.D., Michigan

SIRS: We doctors have listened to the drivel about the high cost of

medical care for so long that we're beginning to believe it ourselves. We apologize for our justly earned fees, and we publicize and exaggerate our faults.

Let our spokesmen in the A.M.A. take the initiative and broadcast our good points, for a change. Let them emphasize the number of hours we work, our take-home pay (not gross receipts), our billion-dollar giveaway, and our high mortality from overwork.

M.D., Montana

SIRS: Medical costs-including hospital bills, medical fees, medicines, and nursing care-are simply a reflection of wages. When wages go up, so does everything else. Before

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#### LETTERS

labor complains, then, about the high cost of medical care, it had better recognize that the trouble is largely of its own making.

W. A. Chipman, M.D. Detroit, Mich.

#### Extra for Caesarean

Sins: In your article on Dr. Broen's fee forms you say, "There will, of course, be an extra charge for such eventualities as multiple birth, Caesarean section, and circumcision." What do you mean by saying "of course"?

I've practiced in two large cities—one in the East, one on the West Coast. In neither city do the best obstetricians charge any more for a Caesarean than for a "normal" delivery.

Incidentally, I believe more Caesareans are performed in communities where an extra charge is made. Is this a coincidence?

And \$20 for a circumcision!

M.D., California

#### **Growth Stocks**

Sins: Readers of your article on growth stocks may have been discouraged unnecessarily by the statement that these stocks "pay belowaverage dividends." A study made recently by my staff shows how temporary this disadvantage may be.

In this study, the performance of ten typical high-grade income-type stocks was compared with ten standard growth stocks during the decade 1940–1950. We assumed \$10,000

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BASIC in Antidiarrheal Therapy

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# Arobon<sup>a</sup>

Whenever diarrhea is encountered in adults, children or infants, and regardless of severity, Arobon is profitably employed as the basic medication. Made from specially processed carob flour, it provides generous amounts of naturally occurring pectin, lignin, and hemicellulose. These complex carbohydrates exert the very actions required for prompt control of diarrheas: They are demulcent, adsorbent, soothing, water-binding.

In simple diarrhea, Arobon suffices

as the sole medication. In infectious diarrhea and dysenteries, it is a valuable adjuvant to specific therapy. Arobon is safe, free from side actions, and does not interfere with nutrient absorption. Arobon is simply prepared: The powder is merely stirred into milk or water, forming a highly palatable drink. Suggested doses: for children and adults, 1 to 2 level tablespoonfuls in milk or water; for infants, 2 to 4 level teaspoonfuls boiled in water.

Simple to Prepare

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is supplied in 5 ounce jars and is available through all pharmacies.

AROBON

THE NESTLÉ COMPANY, INC., WHITE PLAINS, NEW YORK

#### LETTERS

to be invested in each group (\$1,000 per company) at 1940 prices. Here's the result:

the result.		
	Income Stocks	Growth Stocks
1940 investment	\$10,000	\$10,000
1950 value	11,445	26,739
Capital growth	\$ 1,445	\$16,739
Dividends paid,		
1941-1950	5,647	6,103
Capital growth		

Plus dividends \$ 7,092 \$22,842

The difference in capital growth was spectacular, but the point that impressed me most was this: In 1941 the dividends from the ten income stocks totalled \$629 (a yield of 6.29 per cent); the ten growth companies paid out only \$357 (a yield of 3.57 per cent). But by 1950,

while the dividend total from the income group was \$656 (only \$27 more than a decade earlier), the expansion of earning power had permitted the growth companies to pay \$1,114 in dividends.

Thus, though he sacrificed an income of \$272 per year in 1940, the investor who bought growth stocks rather than income-type stocks ended up with a 70 per cent larger annual income and actually received more dividend dollars during the decade.

To check a related point, the price stability of growth stocks, my staff has also compared the price performance of twenty high-grade income stocks, twenty leading cyclical stocks, and twenty growth stocks,

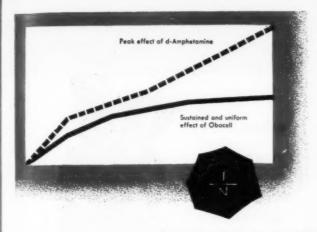
#### DOES A THOROUGH JOB SO PLEASANTLY



60

MEDICAL ECONOMICS · SEPTEMBER 1953

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# HELPS KEEP THE PATIENT ON A DIET LONGER...



\*trwin-Neisler's Brand of High Viscosity Methylcollulose.

Obocell controls the two causes responsible for overeating—bulk hunger and appetite.

Obocell provides a rapid initial release of d-Amphetamine to control appetite at meals, plus a prolonged action for the period between meals.

Nicel\*, a new high viscosity methylcellulose in Obocell, provides non-nutrilive bulk residue to dispel the gnaving sense of emptiness that impels the obese patient to violate his diet. Nicet, moreover, is responsible for the sustained and uniform effect obtained with Obocell, and prevents overstimulation and impairment of sleep as a result of the uniform absorption of d-Amphetamine.

With Obocell it is thus easy to attain and maintain patient co-operation during the trying period of weight reduction.

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At Meals and Between Meals

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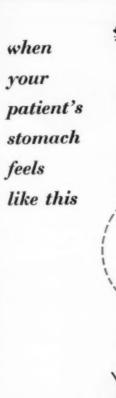
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(Tricyclamol Sulfate and Amobarbital, Lilly)

#### AN IMPROVED ANTICHOLINERGIC AGENT

Relieves spasm and hypermotility of the gastro-intestinal tract, with negligible side-effects. An excellent adjunct to peptic ulcer therapy. Available in pulvules containing 'Elorine Sulfate' (Tricyclamol Sulfate, Lilly), 25 mg., and 'Amytal' (Amobarbital, Lilly), 8 mg.

Average dose: 2 pulvules three or four times a day.

FOR SPASMOLYSIS WITHOUT SEDATION

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(Tricyclamol Sulfate, Lilly)

is offered in 25-mg, and 50-mg, pulvules, Average dose: 50 mg, three or four times a day,

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A greaseless, non-staining cream ... easily removed with water, even from hairy parts ... as acceptable as a cosmetic to patients.



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Compatible with an unusually wide range of both oil and water soluble drugs.

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The pH is close to the pH of normal skin, which helps preserve the acid mantle of the skin.



HARMACEUTICAL CHICAGO 47, ILLIHOIS

Division of Marcelle Cosmotios Smo

#### LETTERS

during the period from 1937 to 1952. Here's what the study shows:

1. The twenty cyclical stocks were the weakest in each period of price decline. They have never exceeded their 1937 value by any worth-while amount. They're still 14.6 per cent below the 1946 peak price, even though the Dow Industrial Stock Average is considerably higher.

2. The twenty income-type stocks followed the Dow Industrial Average fairly closely—falling a little less during price declines and advancing a little less in periods of rising prices. They are now 27.2 per cent higher than in 1937 and 3.8 per cent above their 1946 price.

3. The twenty growth stocks declined less than the other groups in periods of falling prices, and they have shown outstanding capital growth over the sixteen-year span. Their 1946 high was 84 per cent above the 1937 peak; their 1951 price was 59 per cent above the 1946 figure, and 194 per cent above the 1937 level.

David L. Babson Boston, Mass.

#### **Operating-Room Guests**

SIRS: According to a May news item, Dr. Charles U. Letourneau objects to "guests" in the operating room while an operation is under way. He is right. No one should be permitted in the operating room—or anywhere else in the hospital—except those who have work to do there.

Joseph Austin Clarken, M.D. Newark, N.J. for simple, effective conception control



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Ontho Kil Also available: Ortho® White Kit with flat spring Ortho® White Diaphragm.

#### BULLETIN

#### Aspirin Poisoning in CHILDREN

Unfortunately, as so many doctors have learned first hand, the ubiquitous aspirin bottle—so apparently innocuous—often proves a real danger in the home with small children. The risk is not just that a venturesome child may swallow half a bottle. On the contrary, most cases of aspirin poisoning are due to the parents' ignorance of the risk of aspirin therapy in children. Overcoming this lack of knowledge among parents, many doctors feel, is another task the profession must assume.

• The risk of administering aspirin to children is unpredictable, of course, because experience has taught us that the response of fever to aspirin is in part determined by a constitutional tendency, and actual poisoning is determined not only by dosage but by an idiosyncrasy. It has long been recognized, as you well know, that in typhoid fever in children, for example, even a small dose of aspirin may cause a drop of temperature to subnormal, shock-like levels—a drop of nine degrees in an hour having been encountered. And it has been found that in other febrile illnesses similar dramatic results may occur.

• Mother may well be accustomed to taking two or three 5-grain tablets for trivial complaints, even just to "pep" herself up, and so conclude quite wrongly that a single 5-grain tablet is a small dose even for her two-year-old.

Seemingly, educating parents to the fact that aspirin, especially in initial doses, must be used with great caution in infants and children, and dosages should be related to weight, is one more responsibility the busy doctor must undertake.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and will appear monthly in Medical Economics.





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Mephenesin, the safe modern skeletal-muscle antispasmodic, is comparatively insoluble, but becomes freely soluble and hence more readily available when combined with analgesic sodium salicylate. When used alone the effectiveness of mephenesin is almost unpredictable. Salicylates alone will benefit only about 55% of cases. When they are combined in MEPHOSAL satisfying relief of pain and spasm is achieved in over 70% of cases.

Use MEPHOSAL CAPSULES to relieve pain and spasm, increase patient's comfort and ease and range of motion, in the acute low back, arthritis, bursitis, sacroiliac strain, musculo-skeletal strain and trauma, postural musculo-skeletal abnormalities, and other rheumatic conditions.

Each MEPHOSAL CAPSULE contains: mephenesin 250 mg. and sodium salicylate 250 mg.

Average dose: 1 to 2 capsules every 3 or 4 hours, preferably after meals or with a little milk.

MEPHOSAL TABLETS and MEPHOSAL ELIXIR, both of which contain homatropine methylbromide, are also available for use in rheumatic conditions associated with gastro-intestinal disturbances.

samples and literature on request.

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salicylates alone 55% predictable relief



MEPHOSAL 70% predictable relief

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#### BACK PAIN or HEADACHE

Edrisal\* relieves the psychic stress

Edrisal's Benzedrine† component improves the patient's mood and creates a sense of well-being, thus relieving the depression that so often is the underlying cause of pain.

'Edrisal' relieves the pain

"'Edrisal' was more effective than any other analgesic previously used . . ."

Wells, R.L.: M. Ann. District of Columbia 20:360, 1951.

#### Each 'Edrisal' tablet contains:

'Benzedrine' Sulfate . . 2.5 mg. (racemic amphetamine sulfate, S.K.F.)

Acetylsalicylic acid . . . 2.5 gr.
Phenacetin . . . . . 2.5 gr.

Be sure to prescribe 2 'Edrisal' tablets per dose to assure the full benefit of the 'Benzedrine' component.

Also available, for intense pain: 'Edrisal with Codeine 1/4 gr.' and 'Edrisal with Codeine 1/2 gr.'

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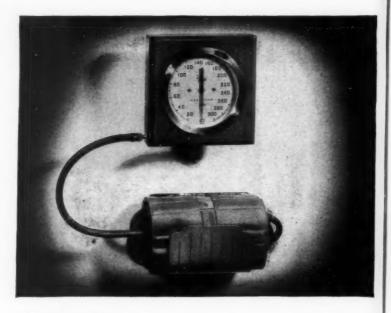
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#### THE NEW TYCOS WALL ANEROID

There's little new under the sun, but sometimes a new design brings amazing results. We think we have done it by adapting the distinctive TYCOS Desk Model to wall use. This new TYCOS Wall Aneroid will give your examining room the efficiency you want, without sacrificing beauty.

Beautiful hand rubbed  $(5'' \times 5'')$  walnut case.

Adjustable reading angle permits adjustment to desired reading position. The convenient cuff holder is brass finished—mounts on wall or wherever convenient.

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You can see this handsome new TYCOS Wall Aneroid at your surgical supply house. Order one for the wall of your examining room and keep your pocket aneroid in your bag for outside calls. Price \$49.50 with hookcuff and 6 ft. of connecting tubing. Taylor Instrument Companies, Rochester, N. Y.; Toronto, Canada.

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#### Invitation to asthma?

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Tedral, taken at first sign of attack, often forestalls severe symptoms.

relief in minutes...Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation. for 4 full bours...Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

Prompt and prolonged relief with Tedral can be initiated any time, day or night, whenever needed, without fear of incapacitating side effects.

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"... the nutrition of the mother largely determines the good health and general resistance of the child ..."

Since the maternal tissues serve as a reservoir from which the fetus must draw all nutritive substances, even borderline deficiencies in Vitamins or Minerals may impair the growth, development and health of the child for the rest of his life. OBRON supplies the OB patient with Vitamins, Minerals and Trace Elements in the amounts necessary to protect her

health and that of her child.

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to help meet the nutritional demands of the OB patient

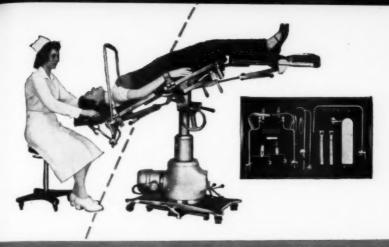
1. Viltner, R. W. and Thompson, C: Nutrition and the Control of Chronic Disease, Public Health Reports, Vol. 66, May 18, 1951.

J. B. ROERIG AND COMPANY . CHICAGO

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#### Each Capsule Contains:

Ener Capoure Contains.		
Dicalcium Phos. Anhydrous*		
Ferrous Sulfate U.S.P 6	4.8	mg.
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The table moves quietly, smoothly from 26½" to a maximum height of 44½" with effortless ease.

Standard equipment includes adjustable headrest, perineal cut-out, irrigation pan, adjustable kneerest, stirrups, and hand wheel operated tilt mechanism. In addition, optional equipment shown above can be supplied.

Ask your Ritter dealer for a demonstration of the new Ritter Medium Surgery Table, or write to Ritter Company, Inc., Ritter Park, Rochester 3, N. Y.



# fost-acting salicylate formula High in analgesic power in risk to the patient

Recent studies 1,2
suggest that the
time-tried salicylates exert a
hormonal action
similar to that of
ACTH, stimulating release of cortisone.

Whenever rapid and sustained salicylate action is desired, ELPAGEN gives your patient the benefits of a potentiated salicylate combination in uncoated tablet form—without the gastric irritation of unmodified salicylates and without the potential dangers (or expense) of ACTH or cortisone itself.

#### ELPAGEN/PATCH

Each orange-colored, uncoated tablet provides:

Sodium salicylate... 5 gr. (325 mg.)
Sodium para-

aminobenzoate... 3 gr. (195 mg.) Salicylamide..... ½ gr. (32.5 mg.) POTENTIATED SALICYLATE BLOOD LEVELS

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Ascorbic acid . . . . . 30 mg. (as sodium ascorbate)

SAFEGUARD AGAINST VITAMIN C DEPLETION AND CAPILLARY HEMORRHAGE

Dihydroxy aluminum aminoacetate, . . . . ½ gr. (32.5 mg.)

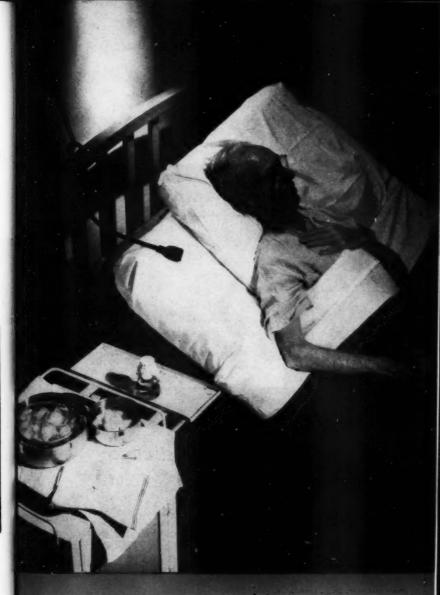
BUFFERING ACTION OVERCOMES GASTRIC INTOLERANCE<sup>3</sup>

SUPPLIED in bottles of 100 and 500 tablets.

Van Cauwenberge, H.: Lancet 261:374, 1951; Van Cauwenberge, H., and Heusghem, C.: Proc. Soc. Exper. Biol. & Med. 80:51, 1952.
 P. Pelloja, M.: Lancet 1:233, 1952.
 Paul, W.D., et al.: J. Am. Pharm. A., Scient. Ed. 39:21, 1950.

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- promptly effective against a broad-spectrum of urinary pathogens
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- well tolerated, even upon prolonged administration

Terramycin is acclaimed by urologists everywhere for unsurpassed action in

chronic urinary tract infections

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"The resistant cases showed remarkable response." ... has cured where all other antibiotics have failed."

Patients with pyelitis were well and doing their usual duties within 24 hours . . . ...

"Morbidity from apparent genito-urinary causes was noted in only one patient of 44 patients who received prophylactic Terramycia."

Terramycia is generally well tolerated, the percentage

of relapses being low and the percentage of bacteriological as well as clinical cures high."

Forguess, C., and Miller, C. D.: J. Urel. 67:762 (May) 1982.
 Trafton, H. M., and Lind, H. E.: Ibid. 69:315 (Feb.) 1962.
 Blahey, P. R.: Canad. M. A. J. 66:151 (Feb.) 1962.



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# For effective antibacterial therapy of SINUSITIS, RHINITIS, OZENA: FURACIN®

without interference with natural defense mechanisms:

FURACIN NASAL

plain . with ephedrine . with Neo-Synephrine\*



#### Some advantages of Furacin:

- no slowing of ciliary action
- · no delay of healing
- no interference with phagocytosis
- no inhibition of nasal lysozyme



Formulae: Furacin Nasal plain contains Furacin 0.02% brand of nitrofurazone N.N.R. dissolved in buffered, isotonic, aqueous solution. Furacin Nasal with ephedrine contains ephedrine \*HCl 1%. Furacin Nasal with Neo-Synephrine\* contains phenylephrine 0.25%. ½ fl. oz. bottles.

 Neo-Synephrine is the registered trade mark of Winthrop-Stearns, Inc., for its brand of phenylephrine which is contained in this solution.

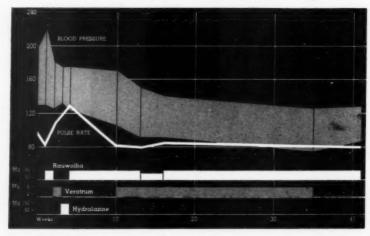
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OTHER DOSAGE FORMS OF FURACIN INCLUDE:
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#### Every patient with essential hypertension is a potential candidate for Raudixin therapy

Because of its safety and the stability of its hypotensive effect, Raudixin can be confidently prescribed for all patients with essential hypertension. It is especially recommended for the large, indeterminate group whose symptoms are not severe enough to warrant the use of other hypotensive agents. Critical adjustment of dosage is unnecessary.

In more advanced cases, Raudixin is a valuable adjunct to other agents.



This patient's blood pressure was lowered about the same amount by rauwolfia, veratrum or hydralazine. Hydralazine, however, caused undesirable reactions and increased the pulse rate. Veratrum augmented the effect of rauwolfia, and the effect was maintained even when veratrum was discontinued some months later. – After R. W. Wilkins, Ann. Int. Med. 37: 1144, 1952.

#### RAUDIXIN

Squibb Rauwolfia

50 mg. tablets, bottles of 100 and 1000

Raudixin contains the whole powdered root of Rauwolfia serpentina. The wide clinical experience to date still makes the whole crude root the preferred form of the drug.

SQUIBB

## Questions

Collecting delinquent

accounts • Transferring E bonds to save taxes • Patient's consent to operation • Private practice for Army doctors

#### **Delinquent Accounts**

I've just taken my first job as a doctor's aide, and find that my predecessor let a number of accounts run on for several years. I've tried to get some of these people to pay up, but without success What do you advise?

The older the account, the less your chance of collecting. The National Association of Medical-Dental Bureaus says a physician can collect, on the average, only 43 per cent of his year-old accounts, 23 per cent of those that have run two years, and almost none of those that are four or five years old.

So better go after the most recent accounts first. Then tackle the older large ones. And, finally, the old, small accounts.

If you fail to collect, ask your employer about turning the accounts over to a collection agency or collection lawyer. If he approves, make sure the collector you choose practices good medical public relations and is recommended by local lawyers and doctors.

Before turning over any large ac-

counts for collection, be sure the statute of limitations for malpractice claims has expired; otherwise, some unscrupulous debtor may file a countersuit. Be sure, conversely, that the statute of limitations for debts has not expired; for if it has, you can't go to law to collect. [See MEDICAL ECONOMICS, September, 1952, for the statutory limit on debts in your state.]

#### Transferring E Bonds

Years ago, I bought some Series E Government bonds and listed my young son as joint owner, since the bonds were intended to cover his college education. Now I wonder if I can save paying income tax on the interest by having my son cash in the bonds, surren dering up to \$600 worth of them each year. Is this feasible?

No, it's not, and here's why:

It makes no difference who cashes the bonds. The government would probably regard you as the actual owner, since you bought the bonds and presumably have kept control of them.

[MORE—>

#### QUESTIONS

It is possible to save part of the tax by making a clear and irrevocable gift of the bonds to your son, some time before they're cashed. While you'll still have to pay income tax on the interest that has accrued up to the date of transfer, your son will pay any further tax. Only if the redemption value of the bonds transferred in any one year is over \$3,000 will you have to file a gift tax return.

#### **Consent to Operation**

I was on emergency duty at the local hospital when a man was brought in from an auto accident. Although he had been drinking, he was conscious and appeared rational. And he belligerently refused to undergo the surgery that several colleagues and I insisted he needed if he was to live. Finally, I went ahead with the operation anyway; and I'm glad to say that the patient recovered. But three questions trouble me:

- 1. Did I violate the law by operating without the patient's consent?
- 2. Had he died post-operatively, would I have been liable for damages? And
- 3. Inasmuch as the man refused surgery, could I have been sued for letting him bleed to death?
- Yes, technically, you violated the law by operating without the patient's consent. You may operate without consent only if the patient



smaller size easier to swallow

small dosage only 3 capsules daily

#### Natalins

the new smaller prenatal capsules

A nation-wide survey of practicing physicians revealed large size and large dosage to be the greatest deterrents to patient's regular use of prenatal capsules.

Natalins are designed to overcome the disadvantages of the usual large size, large dosage prenatal capsules, yet provide generous vitamin and mineral supplementation. Natalins' small, easy-to-swallow size and small dosage of only 3 capsules daily assure instant, as well as continued, patient acceptance throughout the stress period of pregnancy.



#### Natalins

MEAD JOHNSON & COMPANY Evansville 21, Ind., U.S.A.



#### Vitamin and Mineral Potencies

Nutrient	3 capsules supply		
Vitamin A	6000	units	
Vitamin D	600	units	
Ascorbic acid	100	mg.	
Thiamine	3	mg.	
Riboflavin	4.5	mg.	
Niacinamide	30	mg.	
Pyridoxine hydrochloride	0.6	mg.	
Calcium pantothenate	3	mg.	
Folic acid	1	mg.	
Vitamin B <sub>12</sub> (crystalline)	1	mcg.	
tron (from ferrous sulfate)	22	mg.	
Calcium	375	mg.	
Phosphorus	188	mg.	

Natalins also contain traces of copper, ic, manganese, magnesium and fluo

Supplied in buttles of 100 and 500.



# Bentyl proves more effective than atropine in "Nervous



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The Wm. S. Merrell Company . . . Pioneer in Medicine

#### Indigestion"

McHardyl reports that Bentyl is "superior to atropine" for relief of pain due to pylorospasm. He confirms the work of others that Bentyl is free from significant side effects which permits more general use in nervous indigestion.

When you prescribe Bentyl, you prescribe patient comfort. You will rarely hear patients complain about "belladonna backfire" or dry mouth and blurred vision. Use Bentyl for your next nervous indigestion patient. Relief of G.I. spasm is quick, complete and comfortable.

## **Bentyl**

An exclusive development of Merrell Research



New technic of measuring human motility shows a decrease or complete suppression of intestinal pressure waves, depending on dosage of Bentyl.<sup>2</sup> Bentyl acts by blocking acetylcholine and directly affects the muscle fibers like papaverine.

COMPOSITION: Each Bentyl Capsule or teaspoonful Bentyl Syrup contains 10 mg. Bentyl (dicyclomine) Hydrochloride.

Also Bentyl (10 mg.) with Phenobarbital (15 mg.) Capsules and Syrup, and Bentyl Injection, 10 mg. per cc.

DOSAGE: Prescribe Bentyl, 2 capsules or 2 teaspoonfuls Bentyl Syrup three times daily and at bedtime. Infants and Children, ½ to 1 teaspoonful Syrup 10 to 15 minutes before feeding. Three times daily.

- McHardy and Browne: Sou. M.J. 45:1139, 1952.
- Lorber and Shay: Fed. Proc. 12:90, 1953.

Complete Bentyl bibliography on request.

T.M. 'Bentyl'

for 125 Years

New York
CINCINNATI
St. Thomas, Ontario

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# If Your Patients Can't Toleral

#### Nicotine Actually Bred Out Of The Loaf

John Alden cigarettes are made from a completely new, low-nicotine variety of tobacco. A comprehensive series of smoke tests", completed in 1951 by Stillwell and Gladding, one of the country's leading independent laboratories, disclose the smoke of John Alden cigarettes contains:

At Least 75% Less Nicotine Than 2 **Loading Denicotinized Brands Tested** At Least 85% Less Nicotine than 4 **Leading Popular Brands Tested** At Least 85% Less Nicotine Than 2 Leading Filter-Tip Brands Tested

#### **Importance To Doctors And Patients**

John Alden cigarettes offer a far more sat-isfactory solution to the problem of min-mizing a cigarette smoker's nicotine intake than has ever been available before, abort of a complete cessation of smoking. They provide the doctor with a means for redu ing to a marked degree the amount of nicotine absorbed by the patient without imposing on the patient the strain of breaking a pleasurable habit.

ABOUT THE NEW TOBACCO IN JOHN ALDEN CIGARETTES

John Alden cigarettes are made from a completely new variety of tobacco. This variety was developed after 15 years of research by the after 18 years of research by the Kentucky Agricultural Experiment Station. Because of its extremely low nicotine content, it has been given a separate classification, 31-V, by the U. S. Dept. of Agriculture.



	t., N. Y. 36, N. Y. Dept. E-9 nples of John Alden Cigarettes
Name	M. D.
Address	

#### QUESTIONS

is unconscious or incapable of understanding.

2. Yes, you might have been held liable had the man died after the operation.

3. Under the circumstances, you probably could not have been held liable for letting the man bleed to death.

Speaking generally and from a legal viewpoint, when you operate without consent, you must be prepared to prove that you acted to save the life of a person who couldn't speak for himself. But when a rational patient refuses to give permission, then any operation is technically an assault and lays you open to suit.

#### Army Doctors

I'm about to enter the Army, and I'd like you tell me: Will I be allowed to conduct a private practice in my offduty hours?

In an emergency, of course, you may and should administer necessary medical care to civilians. But under normal conditions, you'll be limited to consultation practice when you're not on duty. You may practice more extensively, according to Army Regulation 40-10, "only when the needs of the community exceed the availability of civilian practitioners." Even then, you'll have to get the approval of your commanding officer. And in no case can you open a private office.

proven pain control with safety **'EMPIRIN'** with Codeine Phosphate

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#### not an estrogen but not anti-estrogenic

In contrast to the possibility of untoward effects from estrogenic therapy, **ERGOAPIOL** (Smith) with SAVIN combines remarkable freedom from side actions. Containing the total alkaloids of ergot, it induces well-defined physiological effects without disturbing the endocrine balance . . . useful in

many cases where estrogenic therapy may prove undesirable. Indications are those of ergot.

MARTIN H. SMITH CO. - 150 LAFAYETTE ST., NEW YORK 13, N. Y.

#### ERGOAPIOL SMITH SAVIN

Complimentary Package on Request - on professional stationery please

84

Today caution surrounds the indiscriminate use of estrogenic hormone therapy - the consensus being that it should be used only in endocrine deficiency.



No ma ing equ Hamilt natura steel-

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# Say **Hamilton**and the choice is yours!

#### **NU-TONE**

The finest . . . traditional richness of wood, in Walnut and Blonde Mahogany



# TIME

#### NU-TREND

Contemporary smartness . . . in Walnut, Silver Grey Walnut and four handsome Colortones in Limba wood

#### STEELTONE

The strength of steel, the warmth of color... in White, Cream White, Jade Green, Washington Blue, Coral and Silver Metallic

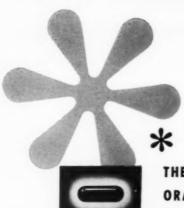


No matter what you're looking for in examining equipment, you'll find it in the extensive Hamilton line. Traditional or modern, in rich natural wood finishes or in color, in wood or steel—Hamilton has the answer. And no

matter which Hamilton suite you select, you have the assurance that your every office hour will be made more productive by numerous Hamilton efficiency features. Say Hamilton—and, Doctor, now is the time to say it!

See these Hamilton suites on display at your Hamilton Dealer's now

Hamilton Manufacturing Company
TWO RIVERS, WISCONSIN



# THERE IS NO SAFER ORAL PREPARATION FOR THE TREATMENT OF HYPERTENSION

Veratrite® brings your hypertensive patients the best therapeutic benefits of Veratrum, since it provides Cryptenamine the newly isolated, broader safety-ratio Veratrum alkaloid developed through Irwin, Neisler research.

Sustained control of blood pressure, with minimum side reactions and maximum safety, is the significant contribution of Veratrite to the long-term management of hypertension.

Each tabule contains:

Supplied: Bottles of 100, 500, 1,000.

## Veratrite

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Research to Serve Your Practice





Stocked by leading wholesale drugsits and surgical supply houses as a ½%, 1% or 2% solution without Epinephrine and with Epinephrine 1180, 2% solution in almost and with Epinephrine 1280, 2% solutions in almost popular with Ripinephrine 1260,000. All solutions discounted in Siere, and 20se, multiple dose visits, packed 5x50er, or \$x50er, to a carton.

Kylocaine® Hydrochloride (Astra) merits special consideration by the busy questhesiologist and surgeon. Profound in depth and extensive in spread, its well-tolerated effect is more significantly measured by the time saved through its remarkably fast action, by which so much normally wasted "waiting time" is converted to productive "working time".

#### XYLOCAINE® HCL

Pronounced Xi telepin

(Brand of lidocaine hydrochloride\*)

AN AQUEOUS SOLUTION

A 4th dimensional approach to preferred local anesthesia

Bibliography available on request



ASTRA PHARMACEUTICAL PRODUCTS, INC. WORCESTER, MASS. U.S.A.

"M.S. Patrick No. 2,447 455



#### "This is what I call SERVICE!"

This Viso-Cardiette technician is reading her latest copy of the bi-monthly Sanborn Technical Bulletin, popular publication which is a continuous and free-of-charge part of our Service-to-Owners picture.

In each issue she finds helpful hints and reminders on Viso (and Metabulator) maintenance and operating procedure, trouble-shooting articles, ideas and techniques developed by other technicians, information on accessories, and the like — all prepared and edited by an experienced staff for the sole purpose of helping her do a better job.

The doctor, too, finds much of interest in the Bulletin—such as results of Bulletin surveys to determine the most commonly used leads and which data spaces are most wanted on mounting cards, notices of postgraduate courses and textbooks, nomenclature and derivation of present-day leads,

news of new equipment, and many clinically helpful articles.

And, the framed certificate proudly displayed in the scene above indicates that this technician has also seen her name in the Bulletin as a "graduate" of the Sanborn Service Course which she chose to take, by correspondence and at a nominal cost, for the information and understanding in operating technique it provides beyond the carefully-prepared Instruction Manual.

These EXCLUSIVE Service Helps are available ONLY to users of SANBORN electrocardiographs and metabolism testers. And both the Bulletin and the Service Course are only part of the many benefits received by Sanborn owners.

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Moderate divretic action, sustained effectiveness, and minimal toxicity

... a clinically desirable compound that makes Calpurate a preferred diuretic in long-term therapy. Calpurate also stimulates cardiac output.

Calpurate—the chemical compound, theobromine calcium gluconate—is remarkably free from gastro-intestinal and other side effects . . . does not contain the sodium ion.

To 'lighten the load' in Congestive Heart Failure

Calpurate is particularly indicated: when edema is mild and renal function adequate . . . during rest periods from digitalis and mercurials . . . where mercury is contraindicated or sensitivity is present . . . for moderate, long-lasting diuresis in chronic cases.

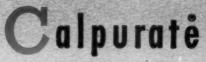
Dosage - may be individualized as necessary

Usual adult dose is 1 or 2 tablets t.i.d., following meals. Where there is a pathological accumulation of fluid, 2 tablets at two-hour intervals for three doses, with a pause until the following day, frequently produces a greater diuresis and avoids habituation.

Usual adult dose of Calpurate with Phenobarbital is 1 or 2 tablets t.i.d., following meals.

MALTBIE LABORATORIES, INC. . NEWARK 1, N. J.

Supplied:
Calpurate Tablets of 500 mg. (7% gr.)
Calpurate Powder
Calpurate with Phenobarbital
Tablets—16 mg. (% gr.)
phenobarbital per tablet



The moderate, non-toxic diuretic

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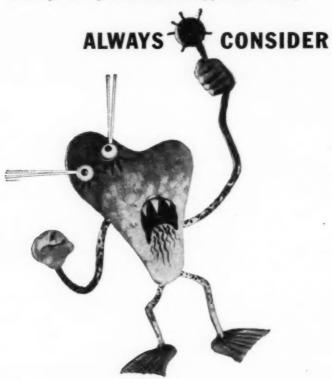
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When you suspect antibiotic hypersensitivity



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#### **ERYTHROCIN\***

#### ... THE SELECTIVE ANTIBIOTIC



#### ORALLY EFFECTIVE

against staphylococci, streptococci and pneumococci—especially indicated when patients are allergic to penicillin and other antibiotics or when the organism is resistant.



#### A DRUG OF CHOICE

against staphylococci—because of the high incidence of staphylococcal resistance to other antibiotics.



#### A DRUG OF CHOICE

because it does not alter normal intestinal flora in a deleterious way; gastrointestinal disturbances rare; no serious side effects reported.



#### ADVANTAGEOUS

because the special acid-resistant coating developed by Abbott-and Abbott's built-in disintegrator assure rapid dispersal and absorption in the upper intestinal tract.



#### Use ERYTHROCIN

in pharyngitis, tonsillitis, scarlet fever, pneumonia, erysipelas, osteomyelitis, pyoderma and other indicated conditions.

\*Trade Mark
Erythromycin, Abbott, Crystalline



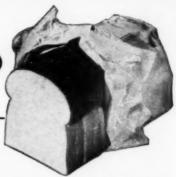
#### what does BREAD

#### contribute?

Some twelve years ago the baking industry began nationwide commercial production of enriched breads. Today such breads represent about three-fourths or more of all the marketed white bread in the United States, and rank high among the foods which contribute essential nutrients—in important amounts—at low cost.

By providing broad distribution of B vitamins and iron in effective amounts, commercial enriched breads have contributed notably to reducing the incidence of deficiencies<sup>1</sup> of these nutrients among patients of charity clinics<sup>3</sup> and have improved the health of a large segment of our population.<sup>4</sup>

Per pound, enriched breads today contribute—as required by government definition and standards of identity.—at least 1.1 mg. of thiamine, 0.7 mg. of riboflavin, 10 mg. of niacin, and 8 mg. of iron.



Thus they are distinctly superior to homemade as well as bakers' white breads of former years.

Each pound of commercial enriched breads contributes also 39 Gm. of protein—wheat flour protein supplemented with milk protein—applicable to growth and tissue maintenance.<sup>2</sup>

Other significant contributions of such breads are 400 mg. of calcium per pound, and calories at low cost.

The table below shows the tmportant nutrient contribution of enriched breads.



The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

#### NUTRIENTS AND CALORIES CONTRIBUTED BY 6 OUNCES OF ENRICHED MARKET BREADS AND THEIR PERCENTAGES OF RECOMMENDED DAILY DISTARY ALLOWANCES?

Nutrients and Calories	Protein Thi	Thiamine	Riboflavin	Niacin	Iron	Calcium	Calories
Amounts	14.5 Gm7	0.41 mg.7	0.26 mg.7	3.8 mg. <sup>7</sup>	4.5 mg.6	150 mg.6	4687
Percentages of Allowances	21%	34%	14%	32%	38%	15%	20%

\*Daily dietary allowances recommended by National Research Council for a sedentary man (154 lb.).

#### AMERICAN BAKERS ASSOCIATION 20 NORTH WACKER DRIVE CHICAGO 6, ILLINOIS

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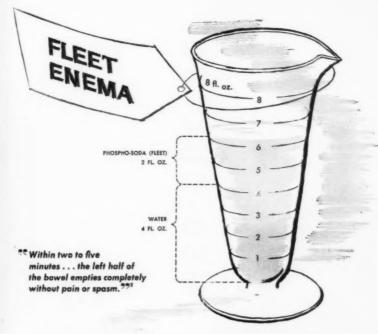


Carnation processing plants throughout America... assuring you the fine quality milk you have come to expect in the familiar

to expect in the famili red and white can.

THE MILK EVERY DOCTOR KNOWS

EVAPORATED MILK



#### Segmental Catharsis

... with the Fleet Enema – safe, simple, time-saving

The only stable aqueous solution of the two U. S. P. soldum phosphates—
containing in each 100 cc. soldum biphosphate 48 Cm. and soldum phosphate 18 Cm.
and soldum phosphate 18 Cm.

... clinically proved 1,3,3,4 by more than four years of extensive use—for preoperative cleansing and general postoperative use—in preparation for proctoscopy and sigmoidoscopy—to relieve fecal or barium impactions—for use in collecting stool specimens—and as a routine enema.

Burnikel, R. H. and Sprecher, H. C.: Am. J. Dig. Dis. 19:191, 1932.
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C. B. FLEET CO., INC., LYNCHBURG, VA.

there is only one

'Phospho-Soda' and 'Flest'

NOTABLY SAFE AND EFFECTIVE WHENEVER LAXATION IS INDICATED

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PHOSPHO-SODA (Fleet)\*

# EO-CULTO

friendly in taste - tastes like chocolate pudding-readily taken by children ... or adults.

> friendly to normal aciduric flora - the type essential to normal peristalsis. Suppresses putrefactive bacteria to obviate distressing flatulence.

friendly in effectiveness - so gentle, no rush, no griping, strain or leakage. Lubricates, softens intestinal contents. Evacuations are moist. comfortably passed.

friendly to the constipated colon

Wide-mouth jars of 6 oz. NEO-CULTOL

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Donnatal Robins' is prescribed by more physicians than amolytic any other spasmolytic



INDEPENDENT SURVEYS CONSISTENTLY SHOW DONNATAL TO BE THE MOST FREQUENTLY PRESCRIBED OF ALL ANTISPASMODICS. THERE MUST BE A REASON! EACH DONNATAL TABLET, CAPSULE, OR S CC. OF ELIXIR CONTAINS: HYOSCYAMINE SULFATE 0.1037 NG., ATROPINE SULFATE 0.0194 MG., NYOSCINE NYOROBROMIDE 0.0085 MG., PHENOBARBI-TAL (1/4 GR.) 16.2 MG. DONNATAL PLUS-SAME FORMULA, PLUS ESSENTIAL B-VITAMINS.

### THUM Safe ANALGES

ASPIRO ( 162 mg (2½ gt.)

PHENACETIN 194 mg. (3 gt.)

PHENOBARBITAL

16.2 mg. (1/4 gr.)

PHOSPHATE
16.2 or 32.4 mg.
1/4 or 1/2 gr.)

HYOSCYAMINE SULFATE 0.031 mg. (1/1000 gr.) through the pharmacislynamic synergism of selected analgesics, sedative and a cholinergic depressant — providing full codeine analgesia, on small codeine dosage.

A. H. Robins Co., Inc., Richmond 20, Va

Phenaphen with Codeine



(World gr.)

PHENAPHEN The original

PHENAPHEN WITH CODEINE PHOSPHATE I'S GO

PHENAPHEN WIR CODEINE PHOSPHATE () Gr (PHENAPHEN No. 3)





#### **Medical Economics**

SEPTEMBER 1953 · VOLUME 30 · NUMBER 12

**Editorial** 

#### The Malpractice Muddle

 Doctors are confronted today with twin specters: rising malpractice insurance rates, and a growing tendency among insurance carriers to shy away from the writing of malpractice contracts.

As a result, some prophets of doom are warning that malpractice insurance will, in time, not be available from any company at any price. We find this hard to believe. But the fact remains that more and more physicians are convinced that they must soon take radical steps to assure themselves the protection they need—and at rates that make sense.

One such "radical" step—an idea that, while not new, has been increasingly advocated lately—might be to have organized medicine take over the job of underwriting malpractice insurance for its members.

A bit too radical? Not necessarily; there's ample precedent for such self-insurance in other fields.

Some years ago, for example, a group of mill owners found fire insurance rates soaring out of sight and policies getting harder and harder to buy. As a way out of their dilemma, they decided to form their own insurance company, which would underwrite their own fire policies. And they wound up with what was generally considered a model program.

A number of cattle owners in another area once faced an even more urgent problem: They couldn't get *any* insurance on their animals. So they pooled their resources and set up an insurance system of their own. It proved mighty effective, too.

Even medicine itself furnishes a precedent of sorts. Cer-

tainly Blue Shield represents a broad—and signally successful—excursion into the insurance field.

Blue Shield isn't self-insurance, though. And we're not, frankly, sure that organized medicine ought to venture into the deep waters of malpractice coverage.

Nor are we the only doubting Thomases. Since the proposal is being rather widely discussed these days, we've talked it over with a number of men who are in a position to evaluate it—insurance executives, for example, and physicians who have served on the malpractice insurance committees of medical societies; and we've found that most of them strongly doubt the practicality of such a program.

One of the men we talked to, for instance, cited "the tremendous amount of money that would have to be put aside as a contingency fund." It would take, he said, "a gigantic pool of funds to start a self-insurance program; and the day after it got going, you might see all the capital swallowed up by one big claim."

Said another: "No field of insurance requires more specialized knowledge than does malpractice. It would be hard to exaggerate the size of the job physicians would face. It's an immense task to round up competent claims men, actuaries, statisticians, and underwriters. And that's only the beginning!"

"I'd rather not even think of the legal problems involved," said one insurance executive. Other men, echoing this sentiment, raised questions, too, of enabling legislation that might be required, state insurance regulations that would have to be satisfied, and so on.

Yet there's obviously something to be said on the other side, too. Curiously enough, an officer of an insurance company that now writes a good portion of the malpractice business told us he sees considerable merit in the proposal. He's quite aware of the obstacles in the way of a self-insurance plan, he said; but, he added, they're by no means insurmountable. And to drive home his point, he made several references to Blue Shield and Blue Cross.

"No one expected those plans to be such a tremendous success when they started," he said. "But their record of accomplishment speaks for itself. I don't deny that it would be a big job for doctors to write their own malpractice insurance. But that doesn't mean it couldn't be done. I think it could."

So there you have it—one proposed solution to the current malpractice muddle, along with some divided opinion as to its workability. Whether or not there's anything to the self-insurance idea, however, this much is clear: Medical men, acting collectively, will have to do something before long. Otherwise, malpractice policies at reasonable rates may follow the horse and buggy into extinction.

-H. SHERIDAN BAKETEL, M.D.

#### Your Medicine—or His Nostrum



MEDICAL ECONOMICS · SEPTEMBER 1953

# Do Druggists Really Supply What You Prescribe?

Many of them don't, according to this report. Instead, the problem of Rx substitution seems to have grown to shocking proportions

#### By Alton S. Cole

 Every doctor knows what can happen when a pharmacist substitutes another drug or brand of drug for the one prescribed. The patient's recovery may be affected, the doctor's reputation damaged.

But it's unlikely that many physicians realize just how widespread Rx substitution has become. Consider some recent evidence:

¶ Almost one out of three druggists substitutes, either occasionally or habitually, on some products.

¶ One-fourth of all prescriptions for certain products are filled by substitutes.

¶ Nine out of ten substitutes are cheap (and dubious) imitations of the product prescribed.

These figures stem from the pharmacists' own magazine, the American Druggist, which recently issued a twelve-page report on what it calls the "critical" situation. Part of the report is based upon a survey of all major, and many minor, prescription specialty manufacturers, leading pharmacists in every state, and all state pharmacy boards.

It's obvious from the report that doctors who have been worrying about the substitution problem have plenty of company. Nearly everyone seems disturbed about it (except, perhaps, the guilty druggists). Substitution has been condemned as unethical by the American Pharmaceutical Association and by other pharmacists' organizations. It's prohibited by law or by pharmacy board ruling in thirty-nine states. In thirty-two of them, a druggist found guilty of substitution can lose his license.

Why, then, has it become so rampant? The report reveals wide differences of opinion as to the cause. But pharmaceutical manufacturers and retail druggists generally tend to line up on opposite sides of the fence.

The chief reason, as given by the manufacturers, is "greed on the part of unscrupulous pharmacists." Many individual druggists, on the other hand, contend that substitution is a matter of economic necessity.

Both points of view are rooted in recent changes in the drug industry. As the report points out, substitution is nothing new. But it has assumed dangerous proportions since the development of expensive drug specialties.

Fifty years ago, there was a mere handful of such specialty products. But today, the magazine observes, "there are thousands of specialties in the physician's armamentarium, and hundreds more are added every year."

How does "greed" come into the picture? Like this: Drug specialties offer tempting opportunities to those who want to turn a fast dollar. Unknown, fly-by-night drug outfits market cut-rate imitations of specialty products. These "counterfeits" can be underpriced because the company that makes them has no research, development, or promotion costs. Nor does it need to enforce quality controls, since it has no reputation to protect.

When druggists substitute such counterfeits for the genuine products that you prescribe, they can charge the patient for the more expensive product and pocket the difference. An imitation of Dexedrine, Nembutal, or of any "miracle" drug, for example, obviously costs the druggist much less than the real thing.

[MORE ]

## DO THEY DISPENSE WHAT YOU PRESCRIBE?

This kind of clear-cut chicanery finds no open supporters among individual pharmacists, according to the report. But many of them do speak up for the right, as a matter of economic necessity, to substitute one reputable brand of drug for another.

They argue that it's unprofitable for the pharmacist to stock all the duplicates among the many different specialty products. If he doesn't have the product the doctor prescribed, they maintain, he should be allowed to dispense a chemically identical one.

## Eight Steps to Take

• The doctor had to get to the hospital fast. He tried to make it across an intersection before the traffic light turned red. Somebody else had the same idea—and the two cars collided.

Nobody seemed hurt, and the cars were only slightly damaged. So the physician—still in a hurry—made a quick verbal promise to "call my insurance man" and went on his way.

It was a rash thing to do. The other driver later claimed that he'd sustained injuries, and the doctor found himself involved in a damage suit. What's more, he was reprimanded by the state motor vehicle bureau for not immediately reporting the accident. And he *could* have lost his driver's license.

With ordinary care, he'd have averted all those troubles. There are certain steps that a careful driver always takes when he has even a trivial accident. First of all, obviously, he stops the car. Then—just as obviously, if he's a doctor—he gives aid to anyone who's been hurt.

After that, what should be done can be wrapped up in eight points. When you've read them, why not tear out the facing page and keep it in your glove compartment? You may find it a handy reference—just in case.

Some typical comments of the retail men:

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¶ "Why should a druggist have to stock ten different brands of the identical chemical compound, thereby forcing him to carry an inventory far greater than his present business justifies?" ¶ "Many new specialties are nothing but varying dosage forms of a single product. On some products, as many as twenty or twenty-five different dosage forms are issued. Why shouldn't the manufacturer simply issue his product in its basic form—most likely a [MORE ON 243]

## After an Auto Accident

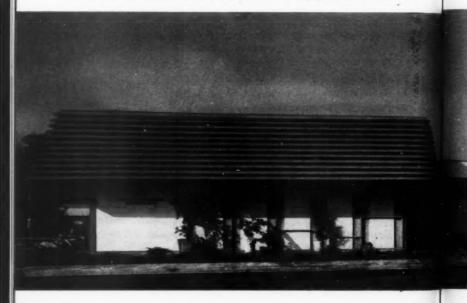
- 1. Exchange information (name, address, phone number, license number, and registration number) with the other driver.
- 2. Warn others if you're blocking the road—especially at night. A flash-light or other signal will do the trick. Don't let your accident cause another.
- 3. Question witnesses to get their names, addresses, and phone numbers. If they're evasive, try to remember what they look like. You'll want to recognize a false witness if one turns up in court.
- **4.** Admit nothing, sign nothing. Questions about payment of costs should be referred to your insurance company. It's not responsible for anything you agree to at the scene of an accident.
- 5. Make a diagram of the accident. Show point of impact. Measure how far the cars skidded, how far they were moved to unblock the road, etc. If you have a camera handy, take pictures; they may show who's responsible for the accident.
- 6. Notify the police by phoning them if you're in town, or by hailing a passing car and asking the driver to do it if you're on the road. Help the police in any way you can when they arrive.
- 7. Report the accident to your insurance company and to the licensing authorities in your state. Do this promptly!
- 8. Consult your lawyer if the smash-up looks serious. Don't discuss—much less make—any settlement without his advice.

# No Bottlenecks In This Four-Man Office

It features a streamlined treatment area that's designed to save the doctors' time and energy

By Roger Menges

DESIGNED TO RESIST HEAT, this cool-looking building is located in Pomona, Calif., 50 miles from the Pacific coast. Grille-like effect at left is a porcelain enamel awning that shields reception room from scorching sun. Awning is permanent, requires no maintenance, can be washed with a hose. In front of the two windows at the right are bamboo screens, a popular California touch.



• How big a reception room will you need in that office you're planning? It will depend to some extent on the size of your practice. But it will probably depend more on the efficiency of your treatment area. For a crowded reception room often reflects treatment-area bottlenecks.

The medical building pictured on these pages serves four busy doctors: a G.P., an internist, a pediatrician, and a surgeon. Yet its reception room is no larger than that in many a one-man office. It seats less than a dozen patients.

There's no need for more waiting space because a streamlined treatment area enables the four doctors to slide their patients through smoothly and efficiently. At the same time, there's no sacrifice of the patients' care or comfort.

[MORE ]



#### NO BOTTLENECKS IN THIS OFFICE

The secret? Actually, there's nothing radically different about the set-up. Its best features have been used by other doctors before. But the way these features have been combined into one workable unit should prove enlightening to any physician who plans an office of his own.

A glance at the floor plan is revealing. You'll see that the treatment area includes eight examining rooms, a lab, and seven other rooms, for X-ray, surgery, and so forth.

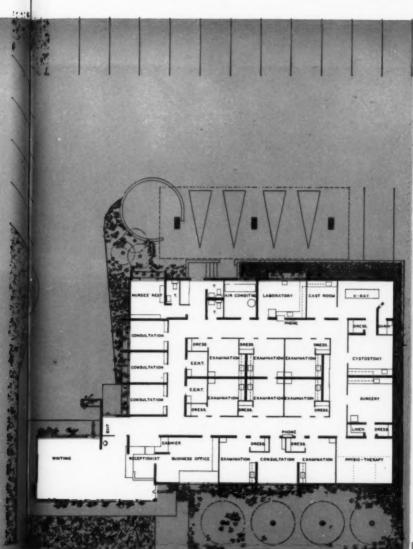
Each examining room has a connecting dressing room. The door between the two rooms locks from the examining room side. When a patient has finished dressing, he leaves the dressing room by a second door that opens into the hall. As a result, the examining room isn't tied up while he dresses.

The two examining rooms in the front of the building are used solely by the doctor whose consultation room they flank. The remaining examining and treatment rooms are used by any doctor who needs them. This allows flexibility for varying patient loads.

Sharing rooms in this way could lead to confusion, embarrassment, and wasted steps. But a signal-light system helps keep things straight. It indicates what rooms are occupied and whose patient is in what room (see photo and description on page 111). Its cost: about \$500.

Rooms used for examination or treatment have neither windows nor skylights because the doctors wanted to give their patients a full sense of privacy. Besides that, they've observed that the absence of windows and skylights has other advantages: There's more wall space for equipment, less load on the air conditioner, and more uniform lighting.

A doctor can be contacted by intercom in any room. In addition, two hall phones are placed strategically in the treatment area so he need not go back to his consultation room to take a call from outside the building. These hall stations are lined with acoustic tile. Each is equipped with phone, intercom, and writing shelf.



MORE-

## NO BOTTLENECKS IN THIS OFFICE



108

MEDICAL ECONOMICS · SEPTEMBER 1953





HIGH CEILING and glass on three sides give reception room a light, airy appearance. In front and on one side, vertical, translucent-glass panels admit a well-balanced spread of light while shielding patients from outside passers-by. Floor-to-ceiling windows provide a view to the rear. On the fourth side is the receptionist's desk, which has formica top and mosaic-tile front to stand rough treatment. To the left of the desk is a hall leading to treatment area. Open door behind desk leads to business office.

[MORE→

#### NO BOTTLENECKS IN THIS OFFICE



RECEPTION DESK annunciator indicates which rooms in the treatment area are occupied. A room number lights up whenever a colored light outside that room is switched on. The intercom alcove and the ceiling above the desk are faced with acoustic tile to keep sounds and conversations from drifting into reception room. Desk is located so that patients must pass it before leaving; thus they're reminded to make future appointments or settle accounts.



OUTSIDE EVERY EXAMINING ROOM is a ceiling fixture with four colored lights. When the nurse leaves a patient in an examining room, she switches on the color that indicates which doctor is wanted. Then she inserts the patient's history card in the rack next to the door. When the doctor glances down the hall, he can see where he's needed next. Dressing room can be entered from the examining room by a connecting door, not visible here. Each dressing room has a table with a built-in hamper for soiled gowns.

#### NO BOTTLENECKS IN THIS OFFICE



EACH EXAMINING ROOM contains equipment like that shown here. The top of the built-in writing shelf at right lifts up and there's space below for pencils and forms. At the lower right end of the combination cabinet and sink is a built-in, ventilated hamper. The sink area is flood-lighted by a concealed fluorescent lamp. Water from the spout, controlled by the usual foot pedal, flows at a constant temperature set by a thermostat. Sliding door between rooms is kept closed during office hours. It's used only in the morning, when the nurse prepares the rooms, as a shortcut from one hall to the other (see floor plan).



FOR PATIENTS WHO DRIVE, there are nineteen parking spaces behind the building. There's also a rear entrance [A], so patients don't have to go around to the front door. To the left of the rear entrance, and separated from it by a thin, protruding wall, is an exit that allows patients to bypass the reception room when they leave. A car port for the doctors [Y] is next to their own private entrance. The circular, concrete-block wall at the end of the car port screens off an incinerator and the air-conditioning equipment.



END

113

## How to Be a Doctor's Wife

## By Lois Marlowe

• DEAR SYLVIA: So you're going to marry a doctor! I'm delighted. I'm pleased, too, that you've asked me to tell you something about what it's like to be a doctor's wife.

Jack agrees that I really ought to tell you *all*. As he points out, I had to learn through experience—and the lessons weren't always easy. So perhaps these letters—I plan to write you several—will help save you some bitterness and exasperation.

Let's take the good things first. Since I've never met your Daniel, I don't know what kind of man he is. Even so, I'm fairly certain of several nice things about him.

To begin with, he's intelligent. He had to be in order to qualify for college from high school, for medical school from college, and for all the examinations he had to pass before he could get his M.D. He must also have good habits of reading, learning, and organization; and he probably respects authority, since his license to practice medicine is governed by a whole set of civil and professional codes.

I don't know how idealistic he is; but it seems to me that a doctor needs a certain minimum of idealism. Otherwise, how could he stand all the worried, cranky, crabby, pathetic, wretched, ungrateful, critical, shrill, helpless people who use up his time and strength?

I would also guess that Daniel isn't a greedy man. If he were, he would never have chosen medicine as a profession. Since he has enough brains to be a doctor, he could certainly make much more money



MMYOBECKER

on a much smaller investment of years and cash.

The chances are, too, that he isn't a wolf or a woman-chaser. I don't mean that he's not likely to be attractive; but medical students do lead a rather monastic life, and they're expected to sleep with their books. In the same way, practicing physicians are supposed to be half angel. So you shouldn't have as much to worry about that way as you might if he were, say, a movie producer. Just stay sweet and understanding, and you'll find that he'll be merely fatherly to his most glamorous patients.

You're fortunate finally, in one respect: Doctors usually love their work. They have to, in order to make the grade. This means that your Daniel will be a contented man if only he can do his work under reasonable conditions. He won't yearn to run off to sea, or switch jobs, or change bosses, or hunt for a gold mine.

His work will probably give him as much satisfaction as anyone can expect from any means of making a living. He'll be free, for the most part, from political pressures and intra-office intrigues. And, since his profession is itself an art and an excitement, he won't

MEDICINAE DOCTOR

<sup>&</sup>quot;These letters to a prospective bride," says Mrs. Marlowe, "are patterned frankly after Anna Davis Hunt's brilliant series of 'Letters to a Doctor's Secretary.' My husband found Miss Hunt's advice so valuable that he asked me, as well as his aide, to read it. As I did so, I kept thinking that the smooth functioning of a physician's office can be upset as much by a poorly oriented wife as by an incompetent secretary, and that maybe, therefore, another series of letters could serve a similarly useful purpose. Anyway, here it is." The author, who writes under a pen name, is married to a New England physician. Two of her letters appear here. Others will follow in later issues.

## HOW TO BE A DOCTOR'S WIFE

need many outside interests; he'll have plenty of outlets for mental and physical creativity when he applies the vast body of his knowledge to a unique problem.

## Too Much Deference

Now that I've listed some of the virtues you can count on, let's take up the minor vices that go along with them. Daniel may well show traits that will annoy and puzzle you—I mean things above and beyond his normal allotment of male idiosyncrasies.

For example, most doctors have come to expect a certain degree of privilege and homage from the rest of the world. In thousands of little ways, and in many big ways, they're deterred to by all kinds of people.

According to hospital protocol, for instance, a nurse must always get to her feet when the doctor approaches or addresses her. If there's only one chair, he may take it while she stands. It's just like royalty, where rank is mightier than chivalry.

If you've ever been in a hospital, you must have noticed the little parade of doctors and nurses making rounds. I doubt if Elizabeth II gets more deadpan deference than His Majesty the Chief of Service gets from everyone in the parade and along the parade route!



The romance of medicine itself can't help giving your doctor some extra stature in everyone's eyes. Ever since he was an interne, remember, he has "starred" in dramas of birth, death, and miracles. He has acted major roles against every background from penthouse to slum tenement. Paths have cleared for him; crowds have melted before him; faces have turned to him with eager hope.

## 'You Must Be Careful'

What does all this mean? It means that whatever he does will always be measured against the fact that he is a doctor. And that's where you come in. You must support this image—to some extent at home, to a great extent outside.

You can't go about, for instance, complaining that your husband drinks too much or sometimes says stupid things, even if he does. You must constantly bear in mind that the doctor is one of the "good guys" of society. He is on the side of the angels.

If you tear down any part of him, you may pull him down altogether. So when the other girls are swapping confidential complaints, watch your step. Your beefing, however innocent, may actually cut into his professional reputation.

"I doubt if Elizabeth II gets more deadpan deference than His Majesty the Chief of Service." In short, you'll never be allowed to forget that you've married not just a man but a medical man.

## How to Present Him

Take the matter of social introductions: Do you introduce Daniel to new friends by his first name, or as Dr. —? That's an important question, believe it or not, and you must find the right answer now.

I've tried it all ways. I've tried the informal method, with the result that people were embarrassed to learn later that the man they'd been chummily calling "Jack" was really a doctor. Then they'd say, "What kind of doctor? Oh, an M.D.? Oh. Why didn't you tell me?"

I could hardly reply that I didn't think the fact important enough to mention, could I?

So finally I discovered that there was only one thoroughly satisfactory way to introduce Jack: by his title and last name. Take it from me: Everyone prefers to have a doctor introduced as a doctor. Keep it formal, and you'll avoid embarrassment and misunderstanding.

In private, of course, you'll be able to treat him like the mere man he really is. But don't be surprised if you have to remind him once in a great while that you're his wife and that *you're* accustomed to a bit of deference too!

One more warning: Again and again, Daniel is going to get your goat by being mysterious about medicine. You'll ask what you think

is a simple question about the common cold—and he'll give you a weary look. You'll describe a friend's symptoms and ask for a diagnosis at which he'll simply sigh, like a man who has had about all he can take.

Finally, you may blow your top and accuse him of being smug. You may complain that you're sick and tired of the way doctors treat laymen. You and he may even quarrel.

To avoid that sort of thing, I advise you not to try to discuss medicine with him. It's an exceedingly complex subject—so complex that most doctors refuse to discuss it with laymen, including their wives. They've learned that if they do talk medicine, they're likely to end up frightfully misquoted and misunderstood.

In my next letter I'm going to tell you what your social life will probably be like. (Very different from most women's, I assure you!) Meanwhile, my best love to you and Daniel.

Affectionately,

Lois

## Social Life

 DEAR SYLVIA: I'm so glad I was right about Daniel! Of course he's wonderful. But let me tell you, darling, you're going to have to be wonderful too.

Remember those movies about the handsome young surgeon who married the lovely but spoiled heir-

ess? He was always running off to some slum to help a crippled kid while she was insisting that with her money he could have his own plush hospital. She'd plan a formal dinner and, just as the roast was being brought in for carving, he'd have to desert his guests for more urgent surgery. He'd ruin one party or weekend after another, and she'd be about to fall for the stockbroker who had plenty of time for her. Then there'd be a fire or a train wreck and the heiress would appear in the last scene at her hero's side, helping with the grim task-Florence Nightingale in an evening gown.

## Part-Time Date

You won't have to go through all that to get the idea that your husband, too, is a part-time date. You'll catch on quickly, and I doubt if you'll fuss much. Nowadays, people seem to be pretty well used to a doctor's hours.

But let's consider your social life from another angle. Suppose you've invited four couples for the evening.

If they're doctors and their wives it won't take the men more than ten minutes to gather at one end of the room and start talking shop. You and the girls will be left to strictly feminine conversation.

But don't fight this. As the saying goes, "It's bigger than both of you."

Your four doctor-guests may differ violently on politics, baseball, or regional loyalty, but they'll purr along with complete contentment



"I am your wife"

about their mutual occupation. The air will be thick with such phrases as "Now, I had a patient who . . ." or "This woman walks into my office with . . ." or "I saw a beautiful case of it when . . ." There'll be lots of multi-syllabic words, too, which they'll toss about as lightly as slang.

You may be able to interrupt them with a good buffet supper. But if you're really smart, you'll let the men go right on while they stand around with their plates of cold cuts and potato salad.

When everyone's gone home, Daniel will give you a grateful kiss and compliment you on your rare understanding.

## When Laymen Gather

Of course you'll also want to entertain friends who aren't connected with medicine. Perhaps your Daniel is one of those well-balanced fellows who truly like people and can stimulate or be stimulated by all kinds. If so, you're lucky. You'll have gay parties with charming people and cozy evenings with intimate friends.

But be careful. A professional man at a social gathering of non-professionals is always a bit on his mettle. One doctor we know, for example, hates to say "How are you?" because so many people he's introduced to take it as a serious inquiry and give him the full medical details.

Some visitors invariably seize the opportunity to compare *their* doctor's diagnosis and treatment with *your* husband's opinion—right in the middle of the living room. [MORE—)

## HOW TO BE A DOCTOR'S WIFE

Others go into long stories about the illnesses of their friends. (This kind usually sets out to prove that doctors don't know anything anyway, and that if a person who's sick really wants to get better, the thing for him to do is go to a chiropractor or simply stay home.)

The point is that if someone at a party asks your husband a medical question, he can't answer freely. And he certainly can't comment publicly on another man's handling of a case.

## M.D. Omniscient?

I've noted that when there's general discussion at a gathering, people will often ask the doctor's opinion—even about non-medical matters on which he may be less well-informed than others present. This can create a problem, too.

Sure, the medical man has had a liberal arts education. And he's looked upon as a leading citizen. And he most likely tries to keep up with what the newspapers, magazines, radio, and television offer. But consider how much of his spare time has to be devoted to professional reading. If his knowledge of what's current in, say, politics, economics, books, and art is a bit spotty, it's not to be wondered at. Encourage him, if the talk ever gets around to any such subject, to tread warily.

I recall how, during the last election, one of Jack's colleagues gave a roomful of people the worst dose of political hogwash and misinformation they'd probably ever had. Among those present were two lawyers who knew the facts and who quickly made the doctor look like a jackass.

## **Need for Caution**

The M.D.-conversationalist, then, must know what he's talking about. Or his wife must steer him away from subjects he's not his best at. Or he must plan most of his social life among other doctors and their wives.

Some of your own women guests in the afternoon [MORE ON 240]

## Always a Gent

• As I stitched up the gash over the woman's right eye, I was surprised at the cleanness and depth of the laceration.

"Did you say your husband did this with his bare fist?" I asked.

"Of course," she answered in a hurt voice. "He wouldn't use no weapon on a lady!"

—JOHN L. MEYER II, M.D.

# Insurance Proceeds: When Are They Taxable?

Some must be reported as income; others needn't be. A tax man tells you how to draw the line

## By Alfred J. Cronin

• When you collect on an insurance policy, must you report the amount as income on your Federal tax return? Before you can answer that question, you have to consider the terms of your policy. There's often a thin dividing line between taxable and non-taxable insurance proceeds.

Take life insurance, for example. When the insured dies, the proceeds are usually paid to a designated beneficiary. If you are the beneficiary and have paid nothing for your rights under the policy, the proceeds are non-taxable on your Federal return, whether paid in a lump sum or in installments.

The installment-payment method (which may be elected by either the insured or the beneficiary) often offers a worth-while tax saving. Suppose a close relative dies and you are the beneficiary of his \$10,000 life insurance policy. You can take a lump sum of \$10,000 immediately or take annual installments of \$1,200 for ten years. By the latter method, you eventually get \$2,000 more than the face value of the policy. This \$2,000 excess comes to you tax-free.

If, on the other hand, you take a lump sum of \$10,000 and invest it in taxable securities, the income thereon will

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be subject to income tax as it is received.

Watch those so-called "dividends" on life insurance policies. They need not be reported as income, because they are merely reductions of premiums previously paid by you. But when such dividends are left with the company, any interest that's paid on them is taxable.

## Retirement Income

Different rules apply when you collect on a policy for reasons other than the death of the insured. Endowments, annuities, and life insurance policies surrendered for cash are examples of this. In such cases, the excess of the proceeds over the net cost is generally taxable as ordinary income; but a net loss is not deductible.

Let's say you have a twenty-year, \$10,000 endowment policy maturing this year. Gross premiums paid were \$7,800. Total dividends received were \$400. Here's how to compute your taxable gain:

Proceeds received\$	10,000
Gross premiums	
paid \$7,800	
Dividends	
received 400	
Net cost of policy	7,400
Fully taxable gain\$	2,600
Note that the dividends re	opived

Note that the dividends received do not count as income, but apply as reductions of premium cost. When you cash in an unmatured life insurance policy, you compute the gain the same way.

#### Annuities

A different tax treatment applies to annuities. The ordinary annuity contract requires you to pay the insurance company a sum of money, either in periodic installments or in a lump. After a designated period, the company starts making installment payments to you or to your beneficiaries. The amount you must report as taxable income in a given year is limited to 3 per cent of the annuity cost; the rest is tax-free. But after the cumulative total of your tax-free proceeds equals the cost of the annuity, all further proceeds are taxable in their entirety.

If you want to deduct a casualty loss for tax purposes, you must first subtract from it any insurance proceeds you've received. The amount of loss is the difference between the property value immediately before and immediately after the casualty. But you're not permitted to claim a loss exceeding the original cost of the property.

## Casualty Loss

Suppose, for example, your summer home was completely destroyed by a hurricane. It originally cost you \$15,000 and was worth \$10,000 just before the storm. The insurance recovery was \$8,000. Your tax deduction is \$2,000.

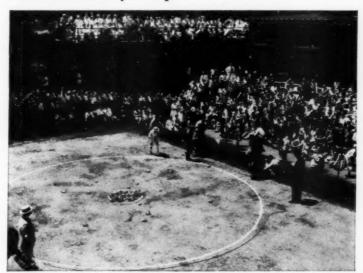
Now suppose the house had cost you \$9,000 instead of \$15,000. Even

though its value was \$10,000 just before the hurricane, your casualty loss cannot exceed the original \$9,000. This time, then, your tax deduction is only \$1,000 after you collect your \$8,000 insurance.

All benefits received under Social Security are tax-free. So, too, in most cases, are payments received from accident and health insurance policies.

But if the payments you receive cover reimbursement for medical expenses that you deducted on a prior tax return, then such proceeds are taxable to that extent.

## **Turtle Finds Derby a Snap**



Jet-propelled, practically, a six-inch turtle hurtled across the circular finish line this summer to win the fifteenth running (?) of the Johns Hopkins Hospital Turtle Derby, held a short distance (but a far cry) from Maryland's Pimlico race track. The 1953 derby took place on the hospital grounds in Baltimore. It attracted 223 hard-shelled entrants (at \$5 a crawl) plus 4,000 fans, prepared to wait all night for a winner. Proceeds were for the benefit of the house staff, and the first turtle to flash over the circle to victory won his owner a colostomy cup.



NATIONAL GUARDSMEN stand watch over a residential area of Worcester, Mass., after the tornado has hit it.

# **Trial by Twister**

By Wallace Croatman

The recent epidemic of tornadoes gave many doctors their first real taste of disaster work. Here's how the physicians of three hard-hit and populous areas met the challenge



• "Few of us had ever seen anything like it before. But there we were, with the injured all around us and no time for thinking. We had a job to do, and we did it."

Thus a Worcester (Mass.) physician has summed up the way he and his colleagues went about the task of treating the more than 500 casualties resulting from the tornado that hit their city not long ago. And his words might have been echoed by doctors in any of the other populated areas where twisters struck this year. For if these ill winds blew any good, it was this: They put medical disaster units to a practical test.

For the most part, the physicians filled roles previously drawn up for them in their hospitals' civilian-defense plans. And the doctors and plans met the test remarkably



**SO MANY VICTIMS** poured into Hurley Hospital in Flint, Mich., that beds had to be set up in the hospital driveway.

well. Best proof of this: Of the injured who reached the hospitals, only a handful died.

Most fatalities in the hard-hit areas occurred outside hospital walls, to those storm-injured persons who were beyond help. In Waco, Tex., for example, the storm killed 114 people, only one of whom reached a hospital alive. The story was similar at Worcester and at Flint, Mich.—the two other prime

victims of 1953's epidemic of tornadoes.

A tornado, nature's most powerful and unpredictable storm, may swoop down with little or no warning. Yet, everywhere that the '53 twisters hit, doctors were on the job in a few minutes. Some of them were summoned by radio and telephone appeals; but most needed no call other than the ominous sound of the storm itself.

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AT THE STORM CENTER in Waco, Tex., Dr. Aubrey Goodman helps to lift an injured woman into an ambulance.

In all three cities, the majority of the medical men rushed directly to their hospitals. But in a few instances—specifically at Flint—roads were so choked with traffic that a few doctors set up makeshift aid stations far from the hospitals.

One example: At Mt. Morris, Mich., near Flint, Dr. Harley H. Anderson used his front yard as an emergency station. He was joined by two other physicians, and also by an osteopath. Working calmly and tirelessly, they handled about 150 cases. They gave first aid to the lightly injured, but sent about sixty of the more seriously hurt on to Saginaw.

All electric power had been knocked out by the tornado. So when darkness fell, Dr. Anderson's emergency team improvised lighting with flashlights and lanterns. Finally, several headlights, taken



VETERANS' HOUSING PROJECT was battered by the Worcester storm. Doctor (right) has just aided a victim.

from automobiles, were set up, powered by batteries commandeered from a service station.

More typical than the scene in Dr. Anderson's yard, though, was the efficient operation of Worcester's Hahnemann Hospital. Only two doctors were on duty when the tornado hit; but minutes later, other physicians began to arrive. During the first night, the hastily gathered staff treated some 200 cases.

Yet there was only one really bad moment. This occurred when the main electric supply failed and the entire hospital was plunged into darkness for about seventy seconds. Finally, an auxiliary unit kicked in—and the doctors went back to work.

## Free of Charge

In general, no efforts were made in any of the disaster areas to charge tornado victims for medical treatment. This policy meant, of course, that doctors were still providing free care for some of the more seriously injured weeks after the catastrophe. One orthopedic surgeon in Flintmet the situation by giving up the afternoons he regularly spent on the golf course. Other M.D.s ungrudgingly



THE UNINJURED, in their eagerness to donate blood, caused major traffic jams by clogging corridors in this Flint hospital.

made other sacrifices of time and money.

Waco physicians, for instance, went beyond simply treating patients free. They also (1) refused to accept a Red Cross offer to pay for their services; (2) raised more than \$5,000 among themselves for the city's disaster fund; (3) voted to turn over to the fund any allowance made by prepayment plans toward the treatment of insured tornado victims.

Numerically speaking, Operation Tornado doesn't stack up as a largescale disaster for this Atomic Age. The combined casualty list of the three hardest-hit cities comes to about 300 killed and 2,000 injured—a drop in the bucket alongside the totals that might confront doctors in the wake of a U.S. Hiroshima. Yet Operation Tornado gave physicians some valuable—and harrowing—experiences.

Most harrowing of all, perhaps, was the experience of Dr. Ernest A. Johnson of Waco, whose office caved in on him. Dr. Johnson's story of what it's like to be buried alive by the whiplash fury of a tornado appears on the following pages.

## The Tornado Buried Him

But this Waco physician survived his two-hour ordeal. Here's his drama-packed story

At 53 years of age, Dr. Ernest A. Johnson, a Waco (Tex.) OALR man, had never seen a tornado. "Then came 4:36 p.m., May 11, 1953. And Isaw one," dryly remarks Dr. Johnson. But 4:36 p.m. is a few hours ahead of the story. So—to begin at the beginning, in Ernest Johnson's own words:

"I'd made my rounds at Providence Hospital that morning, and as I was leaving, the girls at the switchboard stopped me. They wanted to know if I had heard the news about a tornado striking West Texas. I laughed. As a loyal *East* Texan, I said, I wasn't surprised to hear about tornadoes in *West* Texas.

"Without a worry on my mind, I went to my office, which is—I should say was—on the ground floor of the Padgitt Building, an old, four-story structure in the center of Waco. But I kept on hearing about the tornado all through the early afternoon, from patients who seemed to lack my confidence in Waco's immunity from tornadoes.

"I reminded them of an old Indian myth that claims tornadoes can't







UNDER THE WRECKAGE of his office building, Dr. Johnson somehow survives. Here his wife (circled) calls to him as volunteers begin a tough rescue mission.

touch Waco, since it's in a natural protective basin. Some of my patients were cheered, but lots of them just shook their heads dubiously. My, I was amused!

"It was a busy afternoon; and at 4 P.M. there were still about eight or

BEFORE AND AFTER pictures vividly tell story of Waco storm. It wiped out this row of buildings—including Johnson's office (circled).

ten patients due at my office. But most of them never got there. Just at four, it started to rain; great sheets of rain slanted to the street, and there was a deluge of hailstones. This storm, which lasted for almost half an hour, must have turned most of the expected patients back to their homes.

"Then, as abruptly as it had started, the rain stopped. Outside, it was suddenly calm. There was an ominous stillness I can't describe. I can only say that at last I knew we were in for trouble.

"And it came. A howling wind whirled through the streets. Garbage cans began flying past the big windows of my reception room. And when I saw a truck literally tumble out of an alley near the office, I knew this was it. There were six of us (two patients, three aides, and myself) in the office, and we all rushed into the inner rooms.

## **Building Crumbles**

"An instant later, I heard a loud, rumbling noise. Then, in the twinkling of an eye, all was pitch black. One moment I was standing on my feet. The next, the building shook violently, and I was atumble. As I learned later, the three stories above my office had come crumbling down on us.

"I was lifted off the floor and somehow thrown backwards into the rubble. I was sure it was the end, and I prayed for death to be quick and merciful. But suddenly all motion stopped, and I found myself miraculously in a made-to-order pocket of debris, which was just the right size for me.

"I was alive!

"When I finally accepted that fact, I started taking stock of myself. I was pinned down, but most of me seemed to be in fairly good shape. One exception: My left arm was caught, and my left hand was numb. At first I thought it had been crushed off. But I yanked as hard as I could

and somehow got the arm free. I still had a hand and fingers, and I could move them. But the forearm and wrist were badly mangled, deeply lacerated. And I was bleeding profusely.

"But I was alive!

## Nurse Killed

"Then I remembered the others. I started calling out, and I got answering cries from my two patients and two of my assistants. That accounted for five of us, but not for my nurse, Gussie Mayfield. Later, I found out that she alone among us had been killed.

"My first wave of relief at being alive was over now. So I began to worry about getting out of the tomb. Tons of rubble pressed in on us. The dust was choking. A sudden gust of fresh air relieved me on that score, but I also caught a whiff of gas. That odor almost panicked me.

"I might have entirely given up hope, except that I began to hear voices above us. We yelled for help; but for many minutes no one heard us. Then, clearly, I heard a voice calling my name. It was a voice I knew well. It was my wife; and I began to yell more loudly than ever. At first, they didn't hear our screams, but they finally did. Help was on the way.

## Trapped Two Hours

"The next two hours were about the worst. I alternately gave up and gritted my teeth and hung on. All that time, rescue workers—many digging with their hands—struggled to reach us. After two hours, they'd hacked to within three feet of me. And now, mustering all my reserve strength, I squirmed through to them. I just about collapsed as I got within reaching distance of the rescuers. They grabbed me and pulled me the rest of the way."

Dr. Johnson then made his second trip of the day to Providence Hospital. But this time *he* was the patient; he was treated for arm lacerations and back injuries.

## Damage Hits \$30,000

Two weeks later, physically recovered, he began picking up the threads of his practice. He had lost equipment that he estimated was worth \$30,000; and only about onethird of the loss would be offset by insurance. His records had also been destroyed.

The only thing of value salvaged from the wreckage was a sliver of radium, valued at \$5,000, that a Baylor University physicist dug out with the aid of a Geiger counter. Everything else had been carted away in the rubble.

Even so, Dr. Johnson was grateful simply to be alive. Nothing daunted, he soon managed to find temporary quarters in a professional building and to begin assembling new equipment. Thirty-three days after the twister struck, he was back in practice.



HIS ORDEAL OVER, Dr. Johnson rests in a hospital bed and manages a smile.

## Who's Boss in Your Office?

If your aide rules the roost, something is obviously wrong. Here an experienced G.P. offers some cues for correcting the trouble

## By Francis T. Hodges, M.D.

• Though I've carried on a private practice for nearly twenty years, I still get the uneasy feeling once in a while that my office personnel manage me rather than the reverse. When that happens, I start to worry. And I do something about it.

For a medical office should reflect and complement the doctor's professional personality—not his aide's. The practitioner who overlooks this is just asking for trouble.

I'm thinking of several colleagues of mine who've gotten into serious difficulty on this very score. One is a competent, experienced specialist who can't explain why his practice is falling off. But his patients know.

He has a secretary-nurse who long ago jockeyed him out of the driver's seat. Except to the doctor, this woman is cold and brusque to everyone. She bars his office door most of the time, and those who get in are given to understand that it's by her sufferance alone that they're there.

She won't smile. She won't think to call a taxi for a faint patient. She won't even bother to greet a patient by name.

If this doctor would just leave the door to his reception room ajar now and then, he'd know why so many of the return appointment lines in his daily log are empty.

FRANCIS T. HODGES is president of the California Academy of General Practice and board chairman of the California Physicians' Service. This article approximates a talk he gave before a post-graduate assembly of the College of Medical Evangelists.

Since it never occurs to him to do that, he suspects nothing. His secretary has him buffaloed, too.

Another colleague of mine has a svelte secretary who fills out her uniform so well that each line is a question while she's seated and a positive statement when she crosses the waiting room.

The women resent her. The male patients forget what they came for!

She's been with the doctor less than six months, but already she's caused friction and dissatisfaction. The other nurses and secretaries in the building, incidentally, have let it get around that her employer chooses his secretaries with a tape measure.

Of course, it's easy to cite examples of the kind of assistant to avoid. How to find a good one is something else again—if only because a good one does her job with such quiet efficiency that you don't realize she's there.

But even though the right aide may be hard to come by, the extra time it takes to locate her couldn't be spent better.

Any time I've been in the market for an aide, I've made sure of one thing: Applicants understand from the beginning that I insist on the adoption of my methods and my routine.

This may seem like an elementary point to bring up, even in a preliminary interview; but often the stated or implied reply is that the applicant has been doing this kind of thing for years and knows all about it.

Beware of this! It's been my experience that you have here a woman who has learned *her* way of doing things, and, after biding her time, will try to make over the office to suit herself.

I don't say that training and experience aren't important in an aide—simply that, from a doctor's standpoint, how much experience isn't nearly so important as what kind. A nursing course, for example, gives a girl a valuable working knowledge of medicine, doctors, and patients but it's no guarantee that she'll fit into a particular office.

It seems to take some nurses an incredibly long time just to find out that elixir of terpin hydrate with codeine isn't the only way of treating a cough! Nursing training, I'd say, can be a great help to a girl; but it's not mandatory in office nursing and is certainly not essential to secretarial duties. On the other hand, an intelligent nurse with medical secretarial training is of great potential value.

More important than formal training, I think, are those personality traits that fit a girl for work in a medical office. Take just two of the more important ones:

Honesty. This is obviously essential in a field where so much depends on carrying out a task meticulously. Lying to cover up a forgotten telephone call, evasiveness with a patient, doctoring of records rather than tracing back to discover an error, are as serious in their way as the actual filching of funds.

Dependability. This quality in a nurse or secretary is perhaps the greatest load-lifter a doctor can enjoy. Once he knows that a thermometer has been cleaned (not just returned to the pink alcohol to let the mucus congeal on it), once he knows that a certain instrument will always be in its proper place, once he knows that his bills are going out

regularly and that his checkbook balances—then (and only then) can he confidently devote the bulk of his time to treating patients.

## **Hold Reins Lightly**

Of course, it's still essential for him to keep posted on what goes on in his office. He should, for instance, go through his books regularly and check up occasionally on the way office routine is conducted. Any assistant worth her salt will recognize that it must always be his office.

Yet it's possible to stay in charge and be discreet about it. And the office where assistants are treated as trustworthy, dependable human beings is likely to be a well-integrated, congenial place to work.

Graciousness, courtesy, and sincerity belong on a par with ability, training, and technique; for the latter mean little if an aide repels rather than welcomes. A secretary's warm smile, a pleasant voice, a request rather than a curt command, can win and keep patients for even the doctor who sometimes gives the impression of being brusque and hurried himself.

The girl who says, "I'm sorry, Mr. Thomas, but Doctor Hodges will be a little late. Won't you have a chair?" obviously boosts my stock in a big way. Yet how often an aide will snap, "The doctor can't see you now; you can wait in there!" Added courtesies—like opening a window in a warm room or bringing a magazine to a patient waiting in a treatment

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room-can make all the difference in the world.

I try to get my assistants to perform automatically such basic but often forgotten acts as helping a patient on and off a table, providing tissues for the patient slippery with lubricating jelly, draping discreetly, and moving quietly rather than bustling.

#### Operation G.G. Covers U.S.



Whenever and wherever polio struck this summer, medical task forces quickly counter-attacked. But they did more than that. In many areas they gave preventive injections of gamma globulin as well, on a dramatic and heroic scale. They inoculated 33,000 youngsters in Alabama, for example, 35,000 in Western New York State, 13,000 in North Carolina, and uncounted thousands elsewhere. When Dr. Lionel Dichter (above) showed up at the firing line in Elmira, N.Y., one reluctant patient turned out to be three-year-old George Dichter, his son.

#### WHO'S BOSS IN YOUR OFFICE?

If a thoughtful aide can help a practice grow, a thoughtless aide can surely help kill it. Unfortunately, there are some unimaginative nurses who remain in the same room where a patient is trying to pass a urine specimen. The thirty-minute thermometer is another sign of the unthinking aide. So is the proctoscope from a previous patient—

never an appealing study in still life.

Unguarded talk is another sign of discourtesy that's almost certain to solve the problem of a congested waiting room. How would you like to be the gentleman in treatment room A, grimacing as the nurse calls out to the doctor (and anybody else who's interested) that Mr. Brown is waiting for his prostatic massage?



"I'm going to become a doctor and specialize in men."

Or suppose you were anxious Miss Overdue, learning (along with twelve other people) that your Friedman test is positive?

#### Patients' Privacy

Complete privacy should be the right of every patient; but you'd never know it from the way some aides act. I even know of an office where the nurse says proudly, "There are no closed doors here!"

Some assistants seem to feel they're entitled to listen in on every conversation and participate in every confidence. I try to prevent this in my office by means of standing instructions not to press for the presenting complaint with a reluctant patient and by frowning on the reading of patients' charts when there's no good reason for it.

Such a chart is, of course, never left in the room with the patient it relates to. Nor are the charts of other patients left lying around. I've learned, too, not to set down in black and white my occasionally pungent thoughts about a patient, being aware that the entire chart may some day become a court record.

I instruct my staff not to furnish data from a chart to anyone (even though the request sounds legitimate) without a signed release from the patient. That way, at least, they're not so likely to be taken in by a sharp lawyer or insurance investigator posing as someone else.

In the interest of courtesy I also insist that my girls watch their telephone manners. I warn them especially against using the hackneyed device of making the doctor seem so in demand that an appointment can't be had for weeks. Nobody, I maintain, is that busy.

My girls are also instructed to assure the patient that he can be seen, even if the day's schedule is stretched a bit and even if it has to be with the understanding that we can only make a start on the case. The walk-in patient is generally handled the same way, with the tactful suggestion that subsequent visits are better made by appointment.

#### Telephone Technique

My telephone is answered by name, not number. It saves needless time and conversation this way. When an aide calls another number, she always states first who is calling, then what it's about—never, "Is Dr. Jones in?" And before she calls another party for me, she makes sure I can get to the phone right away, so the other person won't be kept waiting.

I also request that telephone conversations be brief (though not brusque), that the secretary keep in charge of the situation without seeming unpleasant about it, and that she avoid vague "er's," "ah's," and "um's."

While I demand warmth and friendliness in my assistants, I discourage coziness and chumminess with patients, long visiting with them, and (without [MORE ON 237]



## At the Head of the

 All the world's a stage, including the medical classroom, says Dr. Walter Freeman [♠], professor of neurology at George Washington University. His teaching philosophy: A good instructor is generally a good actor; if he isn't, he ought to work at becoming one.

But how can a teacher really capture interest? Freeman makes himself the focus of attention by drawing on the blackboard with both hands at once, by using eggs for demonstration purposes, and by strutting across the classroom with a portable microphone.

There are other devices, too, Freeman recently told members of the Association of American Medical Col-



### Class: a Showman

leges. The spellbinding teacher, he says, speaks "without notes, but with emphasis, pauses, gestures, and demonstrations, to prevent that stifling boredom that comes over the student."

The medical teacher, like the actor, says Freeman, should develop "certain idiosyncrasies." He may, for example, "affect loud ties [take a look at Freeman's!] or a carnation in his buttonhole, or even grow a beard." A proud beaver himself, Dr. Freeman favors anything that will help the teacher communicate his enthusiasm and avoid the "passivity" and "spoon-feeding" prevalent in the average medical classroom.

16

## They're Lowering State Licensure Barriers

What with keeping standards up, it's a long, slow process. But already it's getting easier for doctors to move in most directions

#### By Don Cameron

• Seven thousand American physicians last year received medical licenses by reciprocity or endorsement of credentials. It was the seventh straight year since 1946 in which more licenses were issued that way than by examination. And, on the whole, the doctors engaged in the 1952 stirabout found it not too hard to get over the legal barriers guarding the fifty-three medical jurisdictions of the United States and its territories.

This isn't to suggest that the time has come when an M.D. can rove from state to state with complete freedom. But it shows that some headway, at least, is being made in streamlining medical licensure on a national scale.

Two developments—neither of them new, but both grown significantly since World War II—are chiefly responsible:

 Improved cooperation among state licensing boards has brought about a far more liberal attitude than was general fifteen or twenty years ago. The old notion of licensure as a means of restricting competition (among other things) has been pretty well discarded in most states. The current tendency, fostered by the Federation of State Medical Boards, is to accept licentiates of other states strictly on the basis of their qualifications. 2. Increased acceptance of the certificate of the National Board of Medical Examiners, which now is considered adequate qualification for licensure in forty-three states, has opened doors for thousands of doctors. In 1952, endorsement of National Board certificates accounted for nearly 2,700—or around 38 per cent—of the medical licenses granted without examination.

A third development, just shaping up, is a natural outgrowth of the other two. Committees of doctors appointed by the Federation and by the Association of American Medical Colleges met for the first time in June, this year, to begin planning a model medical practice act that will be acceptable to every state. If the program succeeds, its most important result will be uniform state examination and licensure laws that will do away with present confusion and red tape.

But don't count on any immediate miracles from a model law. "It will have to be a long-range program," says Dr. Walter E. Vest, past president of the Federation. "It will take many years, possibly two or three decades, to get such a plan worked out in all the states."

Despite the cheerful news already noted, doctors moving from state to state will continue to have licensure headaches for some time to come. Even with reciprocity or endorsement working in their favor, a good many of last year's 7,000 had their troubles. Some ran into inconvenient and costly delays. Others, exempted from licensure examinations, had to undergo stiff quizzes in the basic sciences.

In addition to these, a number of qualified and licensed men, denied reciprocity or endorsement, had to buckle down and repeat the whole examination procedure to get new licenses. Still others undoubtedly gave up the idea of moving altogether when faced with this alternative.

"Why," asks the doctor who's moving, "can't all li-

censing boards assume that a medical man qualified to treat the sick in one state is just as competent in another?"

To a degree, many of the boards do assume this. Thirty-nine boards now endorse the credentials of applicants whose qualifications they find acceptable. Thirty boards reciprocate with states whose licensure requirements approximate their own. Only Florida demands a written examination of all comers, regardless.

Equivalence of qualifications is the basis for cooperation—and there's the rub. For there just isn't any common ground for comparison of the various examining procedures now in use. To illustrate:

The average number of subjects included in the examinations is ten; but the variations run all the way from four subjects in Alaska to four-teen in Wisconsin.

Similarly, examinations are given over periods of one to five days; and while it may be possible to assess a candidate's qualifications in two days, boards that specify three- or four-day sessions refuse to admit this.

Again, some boards give written tests; one board makes the whole thing oral; the others rely on written-and-oral combinations.

There's no general agreement on passing grades, either. Most boards will pass a candidate on a 75 per cent average. But eight of them specify grades of 75 or higher in each subject, and three require an 80 per cent average.

Licensure by reciprocity or endorsement varies even more. Some states will consider applications at any time. In others, applicants must wait for the regular monthly, quarterly, or semiannual meeting of the board.

Twenty-six states will, under certain conditions, issue temporary licenses to physicians awaiting formal board action. These same states also issue limited licenses to men entering institutional or public health work. A few vacation states provide seasonal licenses for camp or resort physicians.

Examination fees, too, cover a broader range than would seem reasonable—from \$10 to \$100. Fees for licensure without examination generally run double, from \$20 to \$200.

#### **Basic Science Barriers**

To compound the confusion, separate basic science examining boards have been set up in nineteen states, the District of Columbia, and Alaska. Here the diversity of methods and standards presents an even more bewildering picture. Connecticut's basic science board, for example, passes a candidate on a 65 per cent over-all grade; but in New Mexico an examinee must score 85.

Reciprocity among basic science boards is spotty and uncertain. The Florida and Washington boards have none. Others, though allowed by law to reciprocate in some degree, seldom make full use of the privilege.

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ed leThe Rhode Island board stated the case for itself and some others when it announced bluntly that "it does not wish to reciprocate... until... there is greater uniformity among the states with regard to basic science requirements."

Dr. Walter L. Bierring, secretary of the Federation of State Medical Boards, has analyzed the examinations given by a number of basic science boards and found them "by no means easy." They are not to be taken lightly, then—especially by a physician several years out of medical school.

Dr. Jacob L. Lochner, secretary of the New York State Board of Medical Examiners, calls the basic science boards "one of the most important obstacles to interstate endorsement." But medical leaders in general have yet to advocate doing away with the boards. As Dr. Creighton Barker, secretary of Connecticut's Board of Medical Examiners, puts it:

"Even though basic science



MEDICAL ECONOMICS · SEPTEMBER 1953

#### STATE LICENSURE BARRIERS

boards haven't always worked out as well as expected, the reason for them is sound. They're still the most effective instrument we have for weeding out cultists and unqualified practitioners."

Failures among chiropractors and

naturopaths who took basic science examinations in 1952 exceeded 65 per cent. The failure rate for osteopaths was 16 per cent. Failures among physicians, dentists, and medical students totaled 12 per cent.

But because cultists account for

#### Specialists Get Extra-Special Luncheon



Plastic Surgery



**Pediatrics** 



Ear, Nose and Throat



Psychiatry

When the wives of the physicians of Atlanta, Ga., plan a luncheon for their husbands, they don't leave a stone (or a specialty) unturned—even to having table decorations reflect each man's branch of medicine. Here's a discreet sampling of what appeared on the damask at their latest shindig.

only about 4 per cent of those examined by basic science boards, and osteopaths for another 6 per cent, some M.D.s consider the basic science examination a pretty drastic grading device to use on healing arts practitioners in general. They'd like

to find an easy way of controlling the 10 per cent minority without at the same time penalizing the 90 per cent majority (all of whom are medical or dental school graduates and many of whom have additional years of post-graduate training).

The solution, as usual, is more obvious than easy. If basic science laws were uniform, and if basic science boards generally were open to reciprocity and endorsement, there'd be comparatively little need for a physician, once qualified in any state, to be examined again.

#### National Board's Record

Uniform licensing procedures may be a distant hope. But the benefits to be gained from them can be previewed, on a lesser scale, in the results obtained by the National Board of Medical Examiners.

Not a licensing body—and decidedly not in favor of any type of national licensure—the National Board was founded in 1915 by Dr. W. L. Rodman, then president of the A.M.A. Its purpose: to establish an examination of such quality that state boards could grant licenses to those who had passed it without further examination.

This goal has been very nearly reached. Only a few of the fortythree states that accept the National Board certificate do so with reservations, usually disposed of by a brief oral test.

Two states—Indiana and Nebraska—formerly endorsed the certificate



Obstetrics



**Orthopedics** 



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on condition that they could review the examination papers; but when the National Board adopted a new, multiple-choice type of examination this year, legal technicalities forced them to withdraw their endorsement. The other states that don't endorse the certificate are Arkansas, Florida, and Texas.

Eight basic science boards accept the National Board's examination in the basic sciences, which is open to all medical students who have completed two years of work in an ap-

proved medical school.

Says Everett S. Elwood, editor of the National Board's journal, The Diplomate: "Sixteen approved medical schools now require their students to take our examination, and most of the others recommend it. The fact that the examination is accepted by nearly all the states in lieu of their own provides a pretty close approach to uniform standards. Holders of the 26,000 certificates that the board has issued since its foundation come about as near to having universal reciprocity as is possible at this time."

In time, no doubt, something very like the National Board's comprehensive three-part examination will be adopted by most of the state boards. It's the joint product of representatives of the A.M.A. Council on Medical Education and Hospitals, the Association of American Medical Colleges, the Federation of State Medical Boards, the Public Health Service, the Veterans Ad-

ministration, the armed forces, and many leaders in medical education. Licensure authorities generally agree that it's equal to or better than any other examination now given.

#### **Case for State Boards**

As more and more medical school graduates acquire the National Board certificate, the problem of interstate endorsement will shrink proportionately. This does not mean, however, that the National Board or any Federal agency will ever take over the licensing powers now held by the state boards.

Federal licensure would be impossible anyway without an amendment to the Constitution. Nor is it to be expected that any state would surrender its right to issue medical licenses—along with the right to revoke them for cause—to a non-Federal agency.

#### The Summing-Up

To sum up the situation as you'll find it today and tomorrow:

Neither medical licensure laws nor basic science laws can be brought wholly into alignment without the slow and uncertain processes of legislative action. But progress has been made toward scaling down some of the worst barriers, and the outlook is good.

¶ Chances are you'll find it easier henceforth to relocate. Most states will accept physicians who qualify for licensure and will not obstruct those who seek to qualify.

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## **They Pool Their Giving**

By uniting to make their donations to charity, these doctors save time and uncertainty—and give more in the process

#### By Mauri Edwards

• In Santa Monica, Calif., one morning recently, a doctor's secretary sat down to open the mail. In it she found the usual bills, some checks from patients, and three appeals for money from charities.

She put the three appeal letters in an envelope, addressed it to "United Physicians Fund, Santa Monica," and mailed it. Whereupon the doctor's charity problems were taken care of for the day.

When requests for help descend on you, you probably wish you had some easy, automatic way to deal with them, too. As a doctor, you're high on everybody's charity list. Your problem is compounded by the fact that you can't tell a worthy cause simply by the wording of its appeal.

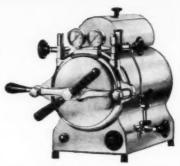
You don't have the time to investigate each organization that asks your support. And, once you've decided to make a donation, you don't have a ready yardstick for deciding how big it should be. So your charity-giving may be haphazard at best.

Until a year ago, this was true of doctors in Santa Monica, too. Then some of them started comparing notes. Result: Thirty physicians worked out a plan to pool their charity resources. By letter, they invited all of Santa Monica's 180 doctors to join them. And, finally, the United Physicians Fund was launched, with 135 mem-

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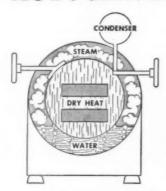
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## **PELTON**

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bers and a pattern for organized

It's a simple plan. A physician joins merely by pledging money to the fund. And the amount he pledges is never disclosed to any outsider. The main proviso is that the amount a doctor contributes in a year meet an established minimum (just how much that is the fund won't say).

Each doctor-member gets a placard to display in his office. And from then on, he can turn his charity problems over to the fund.

Splitting the charity melon is left to a committee of physicians, whose names are carefully shielded from the public. These men screen all requests sent to the fund's doctormembers and then allocate funds. They do it on a percentage basis: 65 per cent for the community chest, for example, and smaller percentages for individual agencies.

One complicating factor: Many doctors have pet charities they've supported for years. The fund's answer is to let members earmark up to 75 per cent of their contributions for such agencies. But at least one quarter must go into the general pool. No money can be tabbed for religious organizations or hospitals unless they're represented in Santa Monica's community chest.

#### Names Are Listed

When the fund mails contributions to the various charities it supports, it lists all its doctor-members. They are then sent cards, pins, or stickers to show their participation.

Listing all names worked particularly well in the most recent Santa Monica community chest campaign. It's a custom of this united drive to publish the names and donations of persons who contribute at least \$100. Unable to single out individual members of the U.P.F., the community chest published the names of all fund members.

Rounding out its first year's operation, the fund points to solid results: It has distributed at least \$12,500; and its officers point out that, without exception, Santa Monica charities have received bigger contributions from physicians than ever before.

In 1951, for example, Santa Monica physicians donated a total of \$4,700 to the community chest. This year, the 75 per cent who belong to U.P.F. donated \$8,300.

#### Information, Please

Starting on their second year of organized giving, Santa Monica doctors plan no change in their operation of U.P.F. But they are allocating a little time to a function they never considered at all a year ago: answering a steady volume of mail from doctors across the country who've heard of U.P.F. and hope it's not too good to be true.

One part of the fund's standard reply that amazes M.D.s elsewhere is that "Overhead costs have been remarkably low." The first year's printing, stationery, and postage

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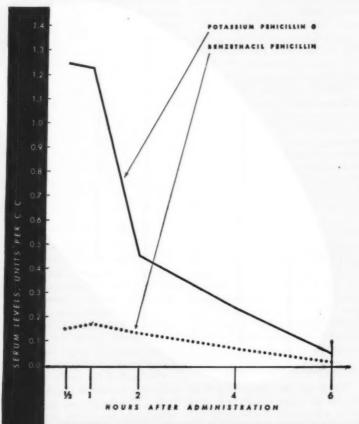
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# Much Higher Initial Peaks More Prolonged Effective Blood Levels



COMPARISON OF SERUM LEVELS OBTAINED FROM SINGLE ORAL DOSES OF 300,000 UNITS OF TWO PENICILLIN PREPARATIONS

Adapted from Foltz, E. L., and Schinmel, H. H.3

Several very recent studies on penicillin plasma concentration and urinary recovery indicate that potassium penicillin G is the penicillin compound most ideally suited to oral medication.

Following oral administration of the two compounds in equal dosage, Foltz and Schimmel<sup>1</sup> observed a considerably higher initial level and a more prolonged effective serum concentration with potassium penicillin G than with benzethacil.

Boger and co-workers<sup>2</sup> found no insoluble salt of the antibiotic to be superior to potassium penicillin G.

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250,000 units\* per teaspoonful (5 cc.)

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50,000 units\* per dropperful (0.75 cc.)

#### Also:

Dramcillin-250 with Triple Sulfonamides
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Dramcillin-250 Tablets with Triple Sulfonamides

1. Foltz, E. L., and Schimmel, N. H.: Antibiotics & Chemotherapy, 3:593-599 (June) 1953.

2. Boger, W. P.; Bayne, G. M.; Carfagno, S. C. and Gylfe, J.; Scientific Exhibit, A.M.A. Convention, New York (June) 1953.

\*buffered crystalline penicillin G potassium

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Vitamin B<sub>18</sub>, 1 microgram
Niacinamide, 50 mg.
Pyridoxine HCl (B<sub>0</sub>), 1 mg.
\*\*Pantothenic Acid (as panthenol), 10 mg.
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\*\*Inesitol, 100 mg.



Calcium (as Ca glycerophosphate), 48 mg. (6.4% MDR)
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Potassium, 10 mg.
Magnesium (as MgCl<sub>2</sub>.6H<sub>2</sub>O), 2 mg.
\*\*Zinc (as ZnCl<sub>2</sub>), 2 mg.

\*\*Zinc (as ZnCl<sub>2</sub>), 2 mg. \*\*Manganese (as MnCl<sub>2</sub>,4H<sub>2</sub>O), 2 mg. Iron (as ferrous gluconate), 20 mg. (200% MDR) Alcohol, 18%

\*\*The need for these substances in human nutrition has not been established. MDR—Minimum Daily Requirement for Adults.



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bill ran less than \$50, and secretarial services cost about \$25. No regular salaries are paid, and there's no overhead for office space, since U.P.F. is headquartered in one or another of its members' offices.

Of course, the fund isn't really unique. A number of business men, for instance, have joined forces to do their giving. But, so far as Santa Monica's M.D.s know, they're the first physicians to try the idea.

#### Looking Ahead

The fund has two big hopes for its second year. Raising more money is, of course, one. The other: That many of the forty-five stay-out physicians will join up.

Actually, says a fund spokesman, "we already have most of the active doctors. Those on the outside are mainly the old, the ill, and those not practicing much. But there are also a few newcomers to town, and some who prefer to do all their own charity-selecting, and some who find objection to any organization."

The point is that the hold-outs are dwindling steadily. For, as the fund spokesman points out, "The doctor who gets swamped by charity requests soon changes his mind about not joining us."



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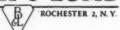


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## If They Don't Know, Nobody Does

With 650,000 volumes to choose from, librarians at the Armed Forces Medical Library generally come up with the answer to any query you send them. And if they can't, they'll admit it

#### By George Beveridge

• One day several months ago, an Iowa physician received a stack of reference cards three inches thick from the Armed Forces Medical Library in Washington. They were just what he needed to pursue a pet research project: They listed all the modern literature, in a dozen languages, on one phase of malnutrition in chronic illness.

What the doctor may not have realized was that behind the little pile of cards were weeks of work, checking and cross-checking bibliographies, reference books, and periodicals. Yet it was the kind of work that the library's staff takes pretty much in stride.

This job was admittedly bigger than average. A good deal less time and energy are required to fill most of the requests that pour daily into the old-fashioned, high-ceilinged reference room of what has been called "the greatest source of medical knowledge in the world."

In a typical day, the library has furnished a Western doctor with a run-down on recent cases of actinomycosis; collected complete statistics for a member of Congress on deaths due to fireworks; brought a Mexico City medical man up-to-date on gamma globulin listings; and supplied a Dutch physician (who had lost his records during World War II) with an exact complication of his own writings. 

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These samples show the variety of data sought from the library by medical researchers, private M.D.s, Federal agencies, and, at times, even patients.

This isn't to suggest that the library can ever be as useful to the practicing physician as it is to the laboratory or clinical researcher. But it can be a valuable addition to the average M.D.'s armamentarium. Unfortunately, many doctors scarcely know it exists.

The main library is housed in a 66-year-old red brick building, mid-way between the Capitol and the Washington Monument. The age of the building creates a few problems.

In a hard rain, for instance, certain parts of the main reading room leak, and library aides rush in to throw tarpaulins over vulnerable stacks of books. One aide recalls entering the room during a storm to find an interne calmly studying a reference book—while holding an umbrella overhead.

#### No Elbow Room

But the greatest shortcoming of the old building is that it's just not big enough to meet present demands.

The library's stock now consists of over 650,000 bound volumes, with over a million titles. About 25,000 volumes a year are being added—requiring a mile of additional shelf space. And the library regularly gets copies of about 10,000 periodicals.

Its rarest treasures—volumes that go back to the early days of medicine—have been stored in Cleveland since World War II. But the overflow has already caught up with the main building. Thousands of volumes are housed in Washington's wartime "temporaries"—wooden structures that are little more than firetraps.

#### Nothing's Overlooked

Subject-wise, the library covers about the same range as any good medical-school, hospital, or medical-society library. Where it stands alone is in the tremendous depth of the subjects penetrated. The library's simple, staggering aim has been to collect copies of all the world's medical literature. Day after day, books, journals, and medical reports of every description pour in from all over the world.

People sometimes question whether this vast undertaking is worth what has to be spent on it. Perhaps it could be justified on academic and historic grounds alone. But Lt. Col. Frank B. Rogers, the library's first permanent director, likes to give more practical reasons.

One justification he cites is the volume of service rendered, as reflected in the many requests for information the library answers. Another is the fact that doctors never know when old, obscure sources are going to provide the answers to an immediate crisis.

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latter cropped up in the early days of the Korean war, when hundreds of U.N. soldiers came down with epidemic hemorrhagic fever. At the time, American M.D.s knew practically nothing about the disease. But they got a running start toward its control when Dr. Claudius F. Mayer of the library staff found reports about it in Russian and Japanese journals dating back twenty years.

#### How to Use It

While Colonel Rogers' staff stands ready to help private physicians, it asks them to check local or state facilities before querying Washington. Say a doctor wants information on a certain technique in abdominal surgery. If he doesn't find what he needs locally, he can write the Armed Forces Medical Library for a list of references. With this list in hand, he can then go further.

He may borrow almost any book (except old, rare volumes) simply by ordering it through his local library. Or he can write directly for photoprints of periodicals (cost: 50 cents for five pages, or 50 cents for fifty microfilmed pages). Last year, the library handled 88,000 orders for photoduplication.

Of the library's own reference works, the most widely used is its Current List of Medical Literature, which every month indexes about 10,000 articles from 1,500 journals. It's available at \$12 a year from the Superintendent of Documents, Washington, D.C.

Sometimes, of course, the library just can't handle a request for information. If the work it would involve is too extensive, the doctor may be sent a list of private research agents.

Occasionally, too, the library must say, simply, "We don't know." This happened recently to the physician who wanted a list of all the current Russian medical journals.

An honest answer like this seems to satisfy most of the library's customers; but once in a while a questioner kicks up a fuss. An irate layman telephoned not long ago from Boston. He wanted to know "immediately" the name of the world's best ophthalmologist—and he announced that he'd hold the wire while the answer was being found. It took the best efforts of three tactful librarians to convince him that he'd better take his problem to a local physician first.



"I'm through with him. He's lost his personality. He's using chlorophyll."

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#### References

- 1. Slinger, W. N., and Hubbard, D. M. (1961), Arch. Dermat. 4 Syph., 64:41, July.
- 2. Slepyan, A. H. (1952), Ibid., 65:228, February.
- 3. Ruch, D. M. (1951), Communication to Abbott Laboratories.

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# Tax Deductions You Can Take On Rental Income

If you're a landlord, you know how maintenance costs have skyrocketed. That's reason enough for saving all you legitimately can on taxes

#### By Alfred J. Cronin

Doctors who double as landlords may well have despaired of their dual role in recent years. While rental incomes have remained fairly constant, material and labor costs have soared. So have utility and insurance rates.

Still, there's at least one cheering note in all this for the doctor-landlord: Most of your rising rental maintenance costs can be deducted on your 1953 Federal income-tax return.

These deductions can thin out your tax burden considerably. But be sure to claim every allowable expense you incur in maintaining your rented-out property. The following items, for example, are all deductible:

¶ Utility costs—the amounts you pay for gas, electricity, water, telephone, heat, and other conveniences you provide under the rental agreement.

¶ Repair outlays—for such things as plastering, painting, plumbing, and all carpentry that cannot be classed as major improvements.

¶ Salaries you pay custodians and service men who care for the property. Also, rental commissions charged by real-estate men.

[MORE→

ALFRED J. CRONIN is a member of the firm of Murphy, Lanier & Quinn, New York, public accountants.

#### TAX DEDUCTIONS ON RENTAL INCOME

¶ Premiums paid on fire or liability insurance during the year.

¶ Taxes for water and land—but not special assessments for such things as new sidewalks or streets, designed to increase the value of the property.

If you rent out part of the house you live in—say, one-half of a twofamily house—then, of course, you can deduct only whatever portion of the operating expenses applies directly to the rented part.

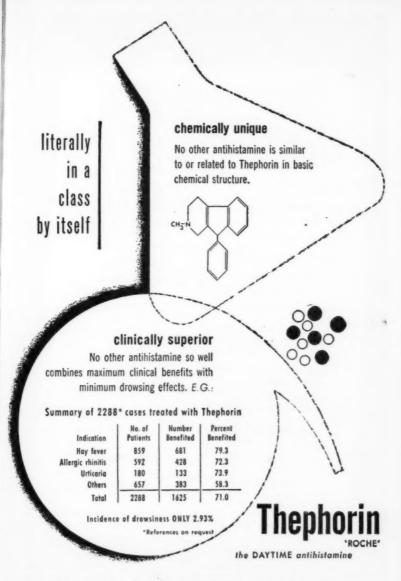
#### **Major Improvements**

Major improvements usually are not deductible in one lump sum. But when the improvement is made for the benefit of a specific lessee, it may be deducted during the term of the lease. If, for example, an operatic tenor lived in a building you owned, you could probably deduct (over the term of his lease) the expense of soundproofing his practice room.

Otherwise, major improvements (like a new heating plant, or a complete redecorating job) must be pro-rated over the life of the property. You should keep a record of all such improvements to verify later claims.

How can you distinguish between "repairs" and "major improvements"? Actually, there is no clear-cut dividing line. A new roof probably would be classed as a major improvement, while replacing half a roof might be only a repair. In gen-





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\*Peshkin, M.M., and others: Ann. Allergy 9:727 (Nov.-Dec.) 1951

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eral, anything that adds to the useful life of your property is a major improvement.

#### Depreciation

Usually the cost of major improvements is absorbed year by year by your deduction for depreciation. When making this deduction, remember to include depreciation on any furniture and equipment that you furnish a tenant. On the other hand, don't include the land your property stands on, for land doesn't depreciate in the ordinary sense.

While you're examining possible deductions from your rental income, don't skip too quickly over the income figure itself. There's more to it than just your tenant's monthly check multiplied by twelve.

#### What's Income?

For example, if he pays you in advance for the months of October through next March, you're required to declare the entire amount on your return for 1953—even though his check covers three months of 1954. Again, if you require payment of one month's advance rent, to be applied to the last month of his lease, this sum must also be reported for the year in which it is received.

Suppose your tenant wants to break his three-year lease before it expires. Suppose he pays you a bonus to cancel the contract. This, too, counts as rental income and must be reported as such. What if you have a working arrangement with your tenant whereby he pays you only \$30 monthly rent, but in addition sends a monthly check for \$50 to your bank as payment on the mortgage? Your income is \$80 a month, as far as the Internal Revenue Bureau is concerned. Whenever the lessee pays your taxes, insurance, or operating costs, you must include these payments both as rental income and as expenses.

But if he decides to equip the bathroom with a stall shower at his own expense, that's different. It's not part of your income, so you won't pay a tax on it—you won't, at least, until you sell the house, when it may show up as a capital gain.



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# Statute of Limitations Is Not Always a Safeguard

You may know what the time limit is on initiating malpractice suits in your state. But are you aware that that limit doesn't always hold?

By Gordon I. Davidson, LL.B.

• Sometimes a doctor sighs with relief when the statutory time limit has passed for a patient to file a malpractice action against him. But perhaps he'd better save his breath. For he may *not* be safe from suit after the usual period.

True, the statute of limitations usually prevents a patient from starting a malpractice suit based on acts that occurred more than one or—in some states—two years ago. But, depending upon the jurisdiction, there are four occasions when this limit doesn't apply:

1. If the patient is a child, the one- or two-year period does not begin until the child reaches age 21. If, for example, a surgeon negligently sets a fracture in a 6-year-old child, he will not be immune to a malpractice action for 16 or 17 years.

2. In many states medical treatment is considered "as a whole"—that is, as involving a continuous relationship. Suppose a physician is negligent in giving a hypodermic injection in January, but continues to treat the patient until December. In states adhering to the theory that treatment is to be considered "as a whole," the statutory period doesn't begin until December, when the doctorpatient relationship ends.

3. In some states, even when a malpractice action is

#### STATUTE OF LIMITATIONS

barred by the statute, the patient can still sue if he believes the doctor broke an implied contract by not using ordinary skill. This is possible because the statute of limitations for a contract is usually much longer than that for a personal injury.

Whether the doctor-patient relationship actually is "contractual" in such a case is a highly technical point of law. Certainly, in many states, damages, if any, would be limited to the patient's out-of-pocket expenses; whereas in an ordinary malpractice action, damages could also be claimed for pain, suffering, disfigurement, mental anguish, etc.

The breach-of-contract theory is not used much because of this limit on damages. But if the statute of limitations clearly prevents a malpractice action, a lawyer may try a breach-of-contract suit.

4. If a doctor's treatment of a patient produces ill effects and if the doctor deliberately conceals those effects, the statutory period is likewise postponed. It does not begin, in most states, until the patient discovers the ill effects—or at least until by reasonable diligence he could have discovered them.

Suppose, for example, a surgeon leaves a sponge in the peritoneal cavity or part of a broken hypodermic needle in the skin. Suppose he does not tell the patient. And suppose, two and a half years later, the patient finds out about it. In most jurisdictions he can then start suit,

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Exerts the full spasmolytic action of Tolyspaz (Chimedic brand of mephenesin) plus the beneficial effects of physostigmine and atropine on the neuromuscular system.

TOLYPHY is specifically designed for the relief of pain, for increased range of motion and restoration of normal function in a wide variety of conditions complicated by skeletal muscle spasm or neuromuscular hyperirritability:

Arthritis, fibrositis, torticollis, bursitis, myositis, low back

Arthritis, fibrositis, torticollis, bursitis, myositis, low back pain. In paralysis agitans the primary pathology in the central nervous system is often irreversible, but TOLYPHY helps bring relief from the stiffness, tremor, rigidity and painful muscle spasm.

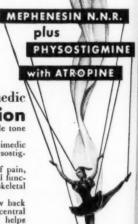
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MEDICAL ECONOMICS · SEPTEMBER 1953



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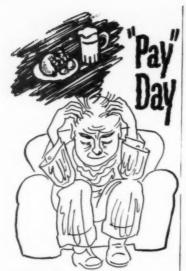
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#### STATUTE OF LIMITATIONS

even though the statute of limitations normally would've barred it.

The courts have held that the doctor's deliberate concealment of the ill effects is a fraud. And the fraud itself is an act of malpractice that continues as long as the patient labors under the deception.

There is one exception to this: If the patient could reasonably have discovered the disability and was dilatory about it, the doctor won't be kept on tenterhooks forever.

Assume, for instance, that the patient had a constantly discharging sinus from the abdominal wall or from the site of an injection and never made any effort to learn why. In most states he could not, ten years later, start a malpractice action, because the delay was his own fault.

What if there is no deliberate concealment by the doctor and if the late discovery of the ill effects is no one's fault? Here, there's no widely-applicable rule. In some states the statute of limitations would still not begin until the patient discovered the ill effects. In other states the doctor would be immune after the normal statutory period ended.

These, then, are the four most common exceptions to the statute. Because of jurisdictional variations, they may not all apply in your locale. If you're in doubt in a particular case, consult your attorney.

And note that the four *are* exceptions. Most of the time the statute of limitations will protect you against unduly belated legal action.

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## Four Easy Ways To Lose an Associate

Finding a good M.D.-associate is only part of it.

The real trick's in keeping him

By John E. Eichenlaub, M.D.

• "I spent months looking for the right assistant and getting him settled here. Then what happened? Within a year, he picked up and left. I tell you, these beginners in medicine don't know what they want!"

I've heard this complaint often. But I disagree with it emphatically.

Several established physicians I know have lost promising young associates. And in almost every such case, the younger man had a good reason for pulling out.

The assistant's dissatisfaction usually stemmed from one of four primary mistakes that senior physicians tend to make. I can think of no surer way to alienate an associate than by following one (or more) of the four methods italicized below:

1. Make promises you may not be able to keep.

One of my colleagues—I'll call him Dr. Armstrong—wanted a top-notch associate. When he found one, he offered him an excellent financial deal: a high minimum guarantee plus a percentage based on the number of patients the new man saw.

What happened? The younger man brought in only a few new patients. But he saw a great many of the senior doctor's old patients.

As a result of this, the practice didn't expand much,

#### "where the liver is damaged

#### administration of

### LIPOTROPICS

is indicated"1



#### IN GERIATRIC PATIENTS

"There is no doubt that many persons, especially those of advanced age, have functional and structural hepatic alterations. Many times the hepatic deficiency is but slightly apparent or nonapparent..."1

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"The present study indicates the uniform presence of liver damage in human obesity as manifested by liver function tests and biopsies."2

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Besage: 1 to 2 tablespoonfuls daily for adults,

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Each orange capsule contains:

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Bottles of 100,

Desage: One capsule three times daily.

For moderate dosage and supplementation

#### LIPOTROPIC CAPSULES

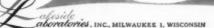
Each pink capsule contains:

Choline dihydrogen citrate 200 mg.

dl-Methionine . . . . 100 mg.

100 mg. Inositol Bottles of 100.

Desage: 1 or 2 capsules three times daily.



#### FOUR WAYS TO LOSE AN ASSOCIATE

and Dr. Armstrong's share shrank more than he had bargained for. So, after a brief trial period, he told his assistant the arrangement would have to be altered.

That did it. From then on, all growth of the practice stopped. The junior man now spent all his extra energy looking for a new job rather than working at the old one.

Before long, Dr. Armstrong was once more in the market for a bright young man.

The point is: Your associate will rightly expect to get whatever you arrange at the start—whether it be money, opportunity for advancement, or specified working conditions. If you make any changes, however fair, in your arrangement, he'll probably feel he's been taken advantage of—unless, of course, the changes are clearly in his favor.

#### Why Should He Work?

2. Fail to give him incentives.

One of the older G.P.s in the city where I practice hired an assistant at a handsome salary. The young man was a sparkplug—ambitious and hard-working. He brought in many new patients during the first year. But soon afterward he began to lose interest; and he finally left.

I ran into him later and found he had taken a job with another doctor. He seemed happy as a lark about it, even though he was earning less money. The important thing, he explained, was that the new job offered him incentive: He was being

paid a salary plus a percentage based on patients seen and new patients gained. This way, he could anticipate future financial reward in keeping with his present efforts.

#### Fogy vs. Squirt

3. Treat him as an inferior.

You'll probably have less trouble understanding your assistant's attitude toward money than his attitude toward you. Today's medical school graduate has been taught to question other people's ideas. He may respect thoughts, arguments, and evidence. He may even place some weight on authority. But he's unlikely to attach much value to ordinary experience. At the same time, he may well overvalue his own assets, notably his youthful energy and his modern scientific training.

You, on the other hand, may feel that your years of practical experience entitle you to overrule the junior man's judgment. And you may, in the process, display a bit of unintended condescension.

The fact is, of course, that the senior man deserves respect, but not subservience. The junior, meanwhile, deserves some freedom of action and the right of a novice to make an occasional mistake without loss of dignity.

One doctor I know has had several assistants but has never been able to keep one. He's a big, jovial man, well liked by his colleagues. He pays his associates well, gives them plenty of time off, and is per-



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#### FOUR WAYS TO LOSE AN ASSOCIATE

sonally friendly and charming. But he has some annoying habits that he doesn't seem aware of. For instance:

He calls his assistants by patronizing names. "Get me a clamp, boy," he'll say. Or "Better give the lady her shot, son." Nor is he above countermanding a younger doctor's orders in front of patients, laughing aside his diagnosis, and wresting his surgical patients from him at the operating table.

Another practitioner I know has an entirely different attitude. And it pays off.

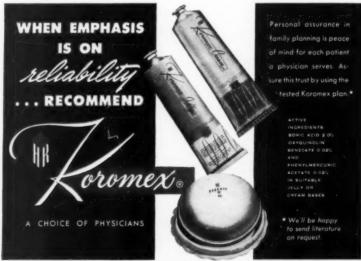
The name of his assistant is displayed in equal prominence with his own on the office shingle and stationery. He leaves the young doctor strictly alone unless he's asked for help. He demands that nurses and secretaries give as much service and respect to the junior as they give to him. As a result, the combined practice runs smoothly and is constantly growing.

#### Time-off Problem

4. Expect him to be the kind of work horse you are.

Men who have been in practice a number of years often say, "I don't know what's got into these younger doctors. Their chief concern seems to be, 'How much time off do I get?'"

Well, let's face it. Most young doctors aren't afraid to work hard. But they *are* jealous of the free time they have, or would like to have,



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#### FOUR WAYS TO LOSE AN ASSOCIATE

for themselves and their families.

Look at it this way: The man who hires an assistant has been inured through the years to constant readiness and continual call. But he's tired—so tired that what he may want most today is a chance for just a few minutes' rest now and then.

His young assistant, on the other hand, wants recreation more than rest. He wants more time with his family at the *end* of the day, not an occasional momentary break during working hours.

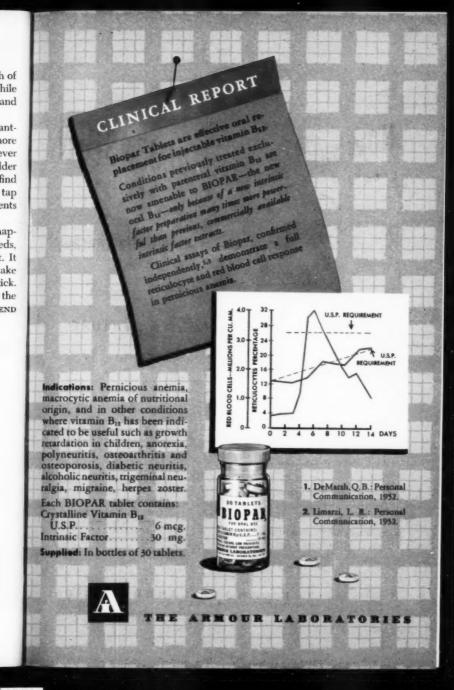
He also wants time off in big enough chunks to let him go places, even if only for a week-end a month. He doesn't feel like shouldering the full burden of private practice (perhaps doubled in weight by much of his employer's patient load) while still enjoying only the position and the income of an employe.

I know one doctor who reluctantly agreed to give his junior more time off than the senior would ever have expected for himself. The older man was agreeably surprised to find that his assistant was usually on tap even during off hours for patients who wanted to see him.

That's the way it generally happens: Consider the assistant's needs, and he'll return the compliment. It takes a lot of give and take to make a senior-junior relationship click. But the rewards are well worth the trouble.



"Hi, Beamish. Long time no fee."





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## Patients *Enjoy* Getting This G.P.'s Bills

Here's a new recipe for smooth patient relations: Keep them posted on medical matters with a monthly letter of fact and opinion

#### By Roger Menges

• Last summer, the wife of a Portland, Ore., plumber looked up from peeling potatoes as her husband entered the kitchen. "Any mail?" she asked. "Only bills," he said.

But a moment later he exclaimed, "Say, this is good!" Then he began to read out loud:

"Dear Friends,

"The thought has occurred to me that opening a stack of bills around the first of each month can be pretty unpleasant... This, then, is my attempt to make one of the most unpleasant parts of medical practice a little less so.

"My plan is to enclose a letter like this with each bill. In these letters I'll try to keep you informed about medical matters that I think you'll be interested in . . . "

The letter went on with a breezy, informal discussion of immunization, polio, and obesity. It was signed by the couple's family doctor.

When the plumber's wife sent a check to pay the bill, she enclosed a short note: "Here's the money we owe you. We enjoyed your letter so much we'd appreciate receiving it every month whether we get a bill or not."

During the past year, Bernard P. Harpole, a 38-yearold Portland G.P., has been sent ninety-three similar requests. As a result, he now mimeographs and mails

when readjustment is a key to

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Arrangements recently completed between Chas. Pfizer & Co., Inc., and Syntex, S.A., now make possible a complete line of steroid hormone preparations available from PFIZER LABORATORIES. On the facing page are listed the initial groups of Pfizer Syntex preparations you can now specify, including Neodrol,\* the newest agent for anabolic effect and tumor-suppression in selected cases with minimal virilizing side effects. Research, discovery, development and wide clinical acceptance have distinguished Pfizer antibiotic agents,

so often the choice of physicians in the control of infectious disease. The scientific research facilities and production controls of both Pfizer and Syntex assure the unsurpassed purity, potency and clinical excellence of the steroid hormone preparations supplied by Pfizer Laboratories.

Additional information on these specialties and their roles in your practice may be obtained by writing directly to Medical Service Department, PFIZER LABORATORIES, Division, Chas. Pfizer & Co., Inc., 630 Flushing Avenue, Brooklyn 6, N. Y.

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Bernard P. Harpole Keeps his patients informed

well over 400 "newsletters" each month, not only to patients who owe him money but also to many who don't.

He hasn't noticed any visible effect on his collections—perhaps because they were already at a high 90 to 95 per cent before the newsletters started. But his patients are enthusiastic and he's convinced that the letters have brought him much closer to them.

#### Pleasant and Helpful

If so, it's not surprising. The letters reveal a great deal about their author. They're warm, chatty, relaxed, unstilted. Though no literary masterpieces, they're indelibly stamped with the human touch. They're never preachy; and they're liberally sprinkled with humor.

Here are some revealing excerpts:

¶ "Chicken pox is on the rampage right now. It's often ushered in with a few days of not feeling well. A typical rash develops over first the trunk and then over the arms and legs. The rash starts with small red spots that turn into little blisters with a dent in the center . . . Treatment is rest, fluids, aspirin, and calamine lotion for the itching."

¶ "Many people think of hygiene as taking a bath several times between week-ends, brushing their teeth regularly (maybe even with grass and fertilizer in their toothpaste), changing their socks every day or two, and maybe chewing their food well. Actually, there's a great deal more to it than that. Hygiene means not just clean, but also healthy, living."

#### Let Them Eat Cake

¶ "Active young children demand a diet high in energy. So they eat cookies, candy, bread, sweet drinks, ices, and everything that isn't 'good' for them . . . But let them eat what they like. I'm sure that many of our dietary problems in later life can be traced to an over-anxious mother who wheedled and begged and beat her toddler into eating food he didn't want."

Dr. Harpole avoids "scare" subjects unless he can give his patients some reassurance. In discussing polio last July, for example, he wrote: "Actually, very few die of polio and very few who contract the disease

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### boon to the millions whose caloric intake must be reduced

Theoretically it is not difficult to organize a diet which will adequately reduce the caloric intake to induce orderly weight loss. If humans ate only to satisfy hunger, it would not be so difficult for the obese to stay on the prescribed diet.

Their excessive appetites and the exaggerated importance which eating occupies in their lives may well be related to psychologic aberrations and obscure frustrations. It is this very perversion of the appetite that makes it so difficult for the obese to remain on the reducing diet.

Even on a well-organized high-protein diet, the craving for something sweet becomes more and more intense, and "cheating" results.

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have any major residual deformities." He then went on to give pointers on how to distinguish polio from other illnesses, so that his patients wouldn't "think that every illness might be polio and worry too much."

In another letter, discussing five childhood diseases, he concluded with these words: "Having all these things is just part of growing up. When your child gets one . . . remember that he's getting it for the last time and doesn't have to worry about it any more."

#### **Dispels Illusions**

Harpole believes in being frank about a doctor's limitations. Here, for example, is what he told patients about colds:

"We have no specific treatment and no way of really preventing them... If you get a fever or severe cough or sinus headache or sore throat, we can help. But when I had my last cold, I asked one of my colleagues what to do for it. He said: 'Wait till it turns into pneumonia, and we'll treat it with penicillin.'"

When sensational stories about medicine appear in the lay press, Dr. Harpole tries to give his patients the proper perspective on them. Not long ago, for example, while the newspapers were playing up lurid accounts of a number of deaths caused by pentothal, he wrote in the newsletter:

"Pentothal . . . is an excellent anesthetic when properly used. It's just as safe as any other. Any anesthetic carries a certain risk. It's too bad that such a good preparation has had such poor publicity."

#### Homespun Philosopher

Occasionally, the doctor gives thumbnail reviews of books he thinks may be helpful to patients. Or he dispenses a bit of practical philosophy. For example:

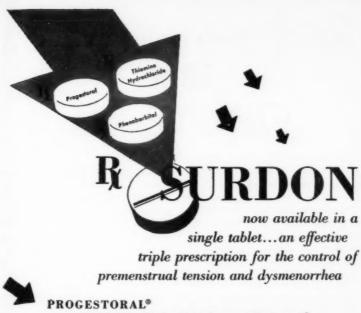
"These are not really very healthy times. We have penicillin, insulin, atabrine, and other miracle drugs; and people are living longer than they ever have. But some of them are living so . . . wretchedly that maybe they'd be better off with a real illness like pneumonia than they are with their tension states . . . Don't let these times push you to the point where you give up the feeling of well-being that comes of living a good life."

Harpole gets his ideas for material to be used in the letters from newspapers, magazines, questions that patients ask, and just about every other possible source. "So far," he says, "I've had no trouble thinking of copy; and I've enough notes to last well into next year."

The physical act of writing is apparently no chore for him. "Usually," he says, "I just mark the paper near the bottom, put it in the typewriter, and type down to the mark."

#### Perfume Started It

The inspiration for his monthly letter came less than a year after he'd opened his own office. Before day



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#### PHENOBARBITAL

Surdon tablets also contain 15 mg. of phenobarbital (approx. ¼ gr.) to allay apprehension, tension and pain—symptoms from which these patients most frequently seek relief.

One or two Surdon tablets per day during the last seven to ten days of the menstrual cycle will usually suffice. Surdon tablets are packaged in boxes of 30.

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October, 1951, he had been in industrial practice with two other physicians. He switched to individual practice, he explains, because "I much prefer patients who come to me because they want to see me, not because they have to."

One day, a few months later, his wife got a bill from a local department store. With it came a piece of perfumed blotting paper. This seemed a nice touch to Harpole; and it provided the inspiration for his own special lagniappe: the newsletter.

#### **Political Action**

Actually, the letter serves several purposes: Besides making patients' medical bills easier to take, for example, Harpole says it gives him a chance to do some unobtrusive political campaigning.

Last fall, he reminded his patients to register to vote, took a few digs at deep freezes and mink coats, and noted that "I have nothing against Governor Stevenson, but I'd sure like to see Ike the next President." He also gave boosts to a doctor up for re-election to the state legislature, to a proposal for a new mental hospital for the aged, and to a bill prohibiting chiropractors from doing surgery.

"Fortunately," he says, "I was on the popular side of the political fence in November. No one seemed to resent my views; and I think I even converted a few people."

Doctor Harpole occasionally gives

his readers "a look behind the reception room," so that they'll understand the mechanics of his work and the problems he faces. Here's what he's had to say about several such things:

#### Inside View

Office hours. "I've insisted on regular hours of working, eating, and sleeping for many of my patients. In order not to be a 'signpost that points the way without ever getting there,' I try to follow my own advice . . . Except for maternity cases, emergencies, and surgery . . . I follow my office hours pretty closely."

Frankness. "I've given a great deal of thought to the problem of telling patients with serious illness exactly what's wrong with them . . . My rule is that if a patient asks me a straight question, I'll give a straight answer."

Night calls. "Have any of you looked at your house number lately? In making calls after dark, I've found that some... are in front of the porch light, some behind pillars or shrubbery, and some are so placed that you can't find them at all. Try driving by your house sometime and see how easily your number can be seen."

Phone calls. "My secretary has 'stalled' many of you when you call in, and asked you if I might call back. You've all been very nice about it, and I've tried to call back as soon as I could. One of the worst

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For convenience of the physician . . . for convenience of the patient . . four powerful antibacterial agents are now combined in this one Lederle tablet.

The additive effect of these drugs makes AUREOMYCIN TRIPLE SULFAS TABLETS outstanding for use against gonococcal infections and against dysentery caused by Shigellae.

For the treatment of bacillary dysentery, this product should be administered on the basis of its aureomycin content at a dosage of 12.5 to 20 mg, per kilo of body weight. The average daily adult dose is 2 tablets 4 times daily, which provides 1 Gm, of aureomycin and 4 Gm, of sulfonamides. Children should receive proportionately less.

For the treatment of gonorrhea, the recommended dose is 2 tablets initially followed by one tablet at 6-hour intervals for 2 doses. This course may be repeated if necessary. BOTTLES OF 12 TABLETS.



# Aureomycin Triple Sulfas



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complaints about doctors is that they make appointments for a certain time and then see their patients two hours later. The constant interruption of telephone calls is one of the reasons for this."

#### He Doesn't Apologize

At times, Dr. Harpole tackles the broader aspects of doctor-patient relations. When he does, he takes the same restrained, realistic approach that he applies to other problems:

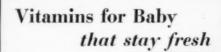
"People have been telling me lately that they feel doctors have changed," he wrote early this year. "They say that . . . we don't seem to pay as much attention to them as we used to, and . . . that it's awfully hard to get us to make house calls.

"Maybe they're right, but I well remember our old family doctor. He was a grand guy and a fine doctor. He had all that we've lost, but unfortunately none of what we've gained in the years since he took care of me. If I had pneumonia, I'd rather wait till morning and have a nurse give me penicillin than have [the physician of] twenty years ago, with all his night house calls and bedside manner."

Harpole said, in the same letter, that "treating the sick has lost much of its human touch." But it wouldn't be surprising if many of his patients disagree with him.



"He just wanted to let me know he was feeling better."



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# Vi-Mix Drops

### Hazards of Joint Ownership

Should you and your wife own property together?

There are certain advantages—plus a good many disadvantages you'll want to think about

#### By Rene A. Wormser, L.L.B.

 A well-to-do doctor I met recently thought he'd found the ideal prescription for his estate headaches.

"Simplest thing in the world," he said airily. "I merely transfer everything I own—real estate, securities, bank accounts—to joint ownership with my wife. Then, if I die suddenly, she'll get it all automatically and immediately by right of survivorship. No will settlement troubles. No legal red tape . . . "

"But plenty of tax problems," I suggested.

He shook his head. "Not the way I heard it. One of my patients has switched to a joint ownership set-up on the advice of his lawyer. He looked up all the angles and found it was the best deal available."

"How big an estate does he expect to leave?"

"Not very large, I guess, apart from the insurance. He and his wife don't own their home. They do own their household effects, a car, and a few thousand in savings."

"And you?"

"Well, my estate should be several times larger, what with the two houses, the office building, and what I have in securities. But otherwise the situation's about the

ickag

RENE A. WORMSER is a member of the New York Bar and moderator of the estate-planning course at New York University. Besides combining a busy law practice with teaching and lecturing, he has written such well-known books as "Personal Estate Planning in a Changing World," "Theory and Practice of Estate Planning," and "The Law."

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join fer same: only the two of us, and each wanting everything to go to the other one."

But my ebullient friend was wrong there: The situation wasn't the same. A full-scale joint property set-up may have been just the thing for his patient, but it would have been bad medicine for the doctor and his wife.

He was quick to see this after I'd recited some of the not-too-well-known facts of death and taxes and mentioned some moral-pointing cases from my own practice. I advised this doctor, as I would any professional or business man, to approach joint ownership with caution, expert guidance, and a lot of forethought. My reasons, I think, will presently be quite clear.

#### For Husband and Wife

The form of joint property ownership generally used by husband and wife is known as "tenancy by the entirety." Under this arrangement, each marriage partner has an equal interest in the property concerned. Neither, acting independently of the other, can transfer his or her share to a third person. On the death of one owner, full title to the property passes automatically to the survivor.

In general, what follows holds good for most such husband-and-wife ownership arrangements. However, there's considerable variation in the state laws that govern the mechanics, rights, and responsibilities of all joint ownerships. In some states different kinds of property are treated differently, so the rules applying to your home won't necessarily apply to your car. And if you happen to live in one state and own property in another, you may find the laws of both states complicating your estate arrangements.

#### Each Case Unique

There are, moreover, twelve "community property" states (Arizona, California, Idaho, Louisiana, Michigan, Nebraska, Nevada, New Mexico, Oklahoma, Oregon, Texas, and Washington) where few of the usual rules apply. If you live in one of these, the information given in this article may or may not be valid for you. No matter where you live, really, you'd better make sure of the exact provisions of the law.

The advantages of joint property sometimes outweigh the disadvantages for the so-called average family whose holdings aren't extensive. Even if your holdings are sizable, a study may reveal excellent reasons for joint ownership of certain property by you and your wife. But each situation should be examined carefully. And in most cases you will quite probably find that joint ownership is inadvisable.

#### Tax Disadvantages

Many people have the curious idea that joint ownership of any property assures its transfer to the survivor without estate tax, fuss, or delay. That just isn't true. But often the truth is discovered by the sur-

#### HAZARDS OF JOINT OWNERSHIP

vivor too late to avoid expense and complications that needn't have been incurred.

The fact is that joint ownership often has drawbacks taxwise. And the larger and more varied the property, the greater those drawbacks will likely be.

As an example of what can happen, take the hypothetical but typical case of the widow of Dr. Smith. The Smiths were joint owners of a home built twenty years ago at a cost of \$12,000. When the doctor died recently, the home was worth \$25,000. Being alone and needing the money, Mrs. Smith sold it. And because profit on the sale of property acquired as the surviving member of a joint ownership is usually figured

from what the co-owners paid originally, Mrs. Smith was taxed about \$1,500 on a \$13,000 capital gain.

If the home had been in Dr. Smith's name and had passed to Mrs. Smith through his will, its \$25,000 value at the time she acquired it, rather than the original value, would have been the basis for figuring profit or loss. In that case, there would have been no capital gain and no tax.

#### Some Other Pitfalls

Nor is that the only pitfall to look out for. When you buy property with your own funds and put it in the names of your wife and yourself, you're making her a gift of an equal interest in the property. This inter-

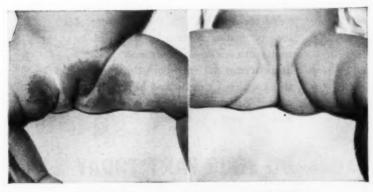


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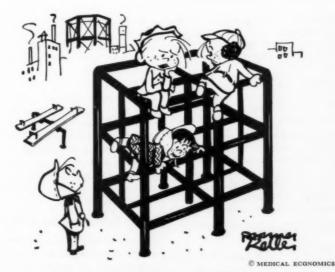
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est is subject to the Federal gift tax if it exceeds your available exemptions and exclusions.

A jointly held property is also subject to the Federal estate tax on the death of one of the owners, to the extent that he contributed to its original acquisition. In fact, the property is taxed wholly in the estate of the first to die, except as the survivor can prove that he or she contributed to its purchase. That's sometimes a tough thing to do, especially when years have passed since the property was acquired.

The law firm I'm a member of handled a case recently that illustrates this difficulty. A husband and wife sold jointly owned real estate abroad and invested the proceeds in a joint brokerage account in this country. There was no real doubt that each owned half the account; but when the husband died, we couldn't prove it. The widow had no records, witnesses, or other evidence of her contribution to ownership of the original property. The estate finally had to pay a tax in part on property that belonged truly and historically to the widow.

Because few people keep adequate records, experiences like this are common. Many a widow is put



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#### JOINT OWNERSHIP

to considerable expense accumulating evidence and fighting an assessment, or else is forced to accept the assessment through inability to prove her point.

#### Accounts and U.S. Bonds

Joint brokerage accounts—like joint checking or savings accounts in banks—pass immediately to the survivor when one of the owners dies. But this doesa't always mean the survivor gets immediate use of the money. In most states such accounts are frozen until the tax authorities have looked into them and released them by waiver.

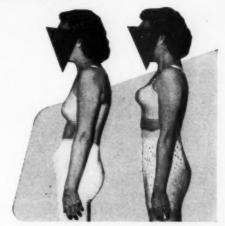
Nor, except in a few states, is the survivor given immediate access to a jointly held safe-deposit box. Usually the box is sealed at the death of one of the co-holders until its contents have been noted for possible tax assessments.

U.S. saving bonds, on the other hand, have a real advantage. The only way you and your wife can own such a bond jointly is to have it registered as belonging to husband or wife. Either can cash it, on his signature alone, at any time. So when one owner dies, the survivor can obtain its money value with no delay whatever.

#### No Substitute for a Will

Joint ownership of property is rarely, if ever, a satisfactory substitute for a will. Its greatest shortcoming may be that, when survivorship rights are in effect, you can't dispose When you prescribe exercises . . .

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The many complex musical scores which an opera star must remember would pose an insurmountable memory problem, were it not for the man in the prompter's box. Thanks to his indispensable reminder function, arias boom forth complete and on schedule to the delight of thousands of opera lovers every year.

While medical practice follows no script, it, too, has a memory problem ... and a "prompter," which few doctors can afford to be without.

The problem is remembering the many pharmaceutical specialties which a physician may want to prescribe in his daily practice.

The "prompter" is PHYSICIANS' DESK REFERENCE—the unique drug reference book that's published annually and used daily in doctors' offices all over America.



#### PHYSICIANS' DESK REFERENCE

one of the best friends a memory ever had

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References: 1. Goldstein, L. S.: Clin. Med. 59:455, 1952.

of the property by will. You've cut off all other heirs and surrendered the right to distribute the property

or put it in trust.

Even if you're certain that joint ownership won't bring any regrets during your life, you may not be looking far enough ahead. For when a husband and wife die together, or within a short time of each other, what becomes of the estate? A joint title contains no "contingent beneficiary" clause. If the husband survives briefly, full title to the property passes to him and then to his family, with no provision for the wife's family.

At the very least, therefore, joint ownership should be backed up by wills for both husband and wife, based on mutual agreement as to how the survivor should dispose of the property eventually.

#### Points to Keep in Mind

Finally, here are four cautions worth keeping in mind if ever you contemplate going in extensively for joint ownership:

- 1. Be sure that, no matter what may happen, you want the property to go to the co-owner and to no one else.
- Have your attorney advise you on the laws of your state with respect to survivorship rights, creation of joint titles, and clearing of joint accounts.
- 3. In the case of salable property that has increased in value, find out how the capital gains tax will affect you. And if the property was bought with independently owned funds, you'd better get and keep proof that both owners contributed towards its acquisition.
- 4. Let a lawyer or tax consultant make sure you haven't overlooked factors that might apply in your particular case. And always remember: The more you own, the more angles you'll have to consider, and the more expert guidance you'll need.

#### Vitamins, Plus

 The patient had asked me to prescribe all kinds of expensive vitamin preparations that he didn't need.

"You'll get just as good results," I told him, "if you'll only eat plenty of fruit. And be sure to eat the skin, because that's where most of the vitamins are. By the way, what is your favorite fruit?"

The patient looked at me glumly. "Coconuts," he said.

—s. c. harwood, m.d.



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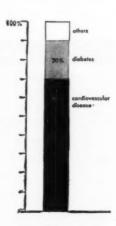
The authors state that the effects resulting from the administration of Monichol are not manifested by any of its component parts which leads them to conclude that Monichol is a "new physio-chemical complex."

In view of the well-established relationship between hypercholesteremia and the incidence of coronary heart disease and diabetes<sup>2</sup> Monichol is indicated in the therapeutic and prophylactic management of hypercholesteremia as associated with these and other diseases.

Formula: Each teaspoonful (5cc.) of Monichol contains: Polysorbate 80 500 mg.

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90% of the patients with hypercholesteremia had cardiovascular disease or diabetes.<sup>1</sup>

### Monichol normalizes cholesterol metabolism

Dosage: I tsp. 4 times daily, or 2 tsps. twice daily, after meals. Supplied: In bottles of 12 oz. Literature available on request.

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1. Sherber, D. A., and Levites, M. M.: Hypercholesteremia.

Effect on Chalesterol Metabolism of a Polysorbate 80-Chaline-Inosital Complex (MONICHOL)

J.A.M.A. Vol. 152:682 (June 20) 1953.

2. Keys, A.: J.A.M.A. 147:1514 (Dec. 15) 1951.

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Over a Quarter Century of Service to the Medical Profession

## Are You Insured Against Liability Claims?

If so, do you know what protection your policy gives—doesn't give? This article may disturb you, but it should open your eyes

#### By W. Clifford Klenk

• Since the average doctor is a man of some means, he's fair game for a lawsuit any time someone is accidentally injured by a member of his family or on his property. Yet a surprising number of medical men neglect to take out insurance that would protect them, at no great expense, against such claims.

Take the case of an OB man I talked to recently:

The flagstone walk in front of his house was in bad shape. He'd been meaning to have it repaired for some time, but hadn't gotten around to it. One night, an elderly woman tripped over one of the broken flags and had a bad fall.

As a result, soon afterward, she brought suit against the doctor, claiming severe back injuries. Although conflicting opinions about the severity of the injuries were presented at the trial, the woman eventually won a \$5,000 judgment. The physician didn't have public liability insurance, so he had to pay the judgment—plus legal fees—out of his own pocket.

True, there isn't much chance, statistically, that you'll find yourself in this kind of jam. But accidents do

W. CLIFFORD KLENK, author of this article, is a well-known New York insurance analyst and consultant.

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happen; and in the event that you should be sued successfully, you could be ordered to pay an embarrassingly large sum of money.

#### **Types of Coverage**

There are two kinds of public liability insurance: (1) schedule and (2) comprehensive (sometimes called personal). A schedule policy limits coverage to a specific location (e.g., your home and its surrounding property). A comprehensive policy, on the other hand, covers not only injuries sustained on your property but also injuries caused by you or your family away from the premises.

Although comprehensive coverage is naturally the costlier of the two, most doctors will probably find it worth the extra premium for the added peace of mind it gives. You can get a \$10,000 comprehensive policy, covering your whole household (but not your office), for as little as \$10 a year—or \$25 for three years. If your office is also in your home, coverage for both will probably run to about \$15, or \$37.50 for three years.

And there's no need to carry two policies if you maintain a separate office away from home. You need simply add to your comprehensive home policy an endorsement for office coverage. Rates for such extra coverage depend pretty much on the size of the office and its location.

Just how comprehensive is comprehensive liability insurance? The best way to answer that, I think, is to consider some of the accidents for which the law might hold you responsible.

Your greatest liability° is to people who visit your home or office on business. This category includes just about everyone, from patient to paper boy.

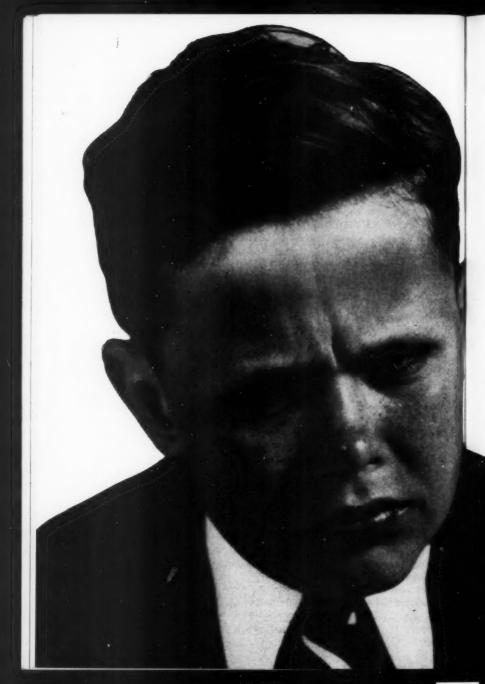
#### What Is Negligence?

If a person who visits you on business is injured on your property, he has no case against you, as a rule, unless he can prove that you were negligent. But the courts tend to take a broad view of "negligence." For example, you might be held responsible even though you didn't know beforehand about the condition that caused the accident. Thus, the mere fact that you didn't know a board in your back steps was rotted wouldn't excuse you if the milkman fell through it.

You're allowed a bit more leeway with non-business visitors: Ordinarily, they assume the risk of hazards in your home that you don't know about. And trespassers, of course, generally invade your property at their own risk.

This last may not hold true, though, if the trespasser is a child. In such a case, you may be in for trouble if you have an "attractive nuisance" on the premises—that is, something likely to prove irresistible

<sup>&</sup>lt;sup>o</sup>Except for malpractice and automobile liability, which, of course, aren't covered by the policies discussed here.



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#### Double antibiotic action



against common gram-positive and gramnegative bacteria often associated with minor oropharyngeal infections. Virtually nonsensitizing, these two effective antibiotics are coupled for maximum topical effectiveness.

#### Fresh orange flavor



distinguishes these palatable candy-like troches for adjunctive use in controlling bacterial multiplication during common infections of the oropharyngeal cavity.

SUPPLIED: 1,000 units (0.1 mg.) polymyxin B and 50 units bacitracin, individually wrapped in boxes of 10.



PFIZER LABORATORIES

BROOKLYN 6, N. Y.

DIVISION, CHAS. PFIZER & CO., INC.

to a normally inquisitive kid. An unguarded fire, a ginger-ale bottle filled with cleaning fluid—even a fish pond that a toddler might stumble into—could fit under the heading of an attractive nuisance.

#### **Curb That Dog**

What about the negligence of your own children? Usually you aren't liable if, say, your 8-year-old son runs somebody down with his wagon. But you might be if, for example, the boy has a reputation for reckless deviltry. In that case, the court might hold you to blame for not having taken the wagon away from the child.

The law also grants some tolerance for your pets' misdeeds. Thus, it's generally conceded that a well-behaved dog is entitled to one "free" bite before the owner can be held responsible. But if you know your dog is vicious, it's clearly up to you to keep him under control.

However, even more important to the doctor than any of these is his responsibility for injuries sustained by patients. I mean, of course, injuries that aren't covered by malpractice insurance.

#### When Patients Slip

Perhaps the most valid argument for carrying comprehensive liability insurance is the protection it provides against this sort of thing. Not long ago, a surgeon-friend of mine had an unpleasant experience that brought the lesson home to him: After completing his examination of a rather stout woman, he helped her up from the examining table. Then, when he felt he could safely leave her—she was in a sitting position, with her feet touching the floor—he turned to wash up. But as he did so, the woman's foot slid on the highly waxed floor and she was down again—this time on the floor, with a broken wrist.

The doctor's high-premium malpractice insurance didn't cover the case; the company claimed that the injury hadn't occurred while the surgeon was treating her, or as a result of his treatment. So he was liable.

But he got off more easily than one of his colleagues, whose patient stumbled into a glass instrument case. Result: a badly scarred face and a very large damage suit.

When you consider all the ways



### W CHEMOTHERAPEUTIC MOLECULE LORED SPECIFICALLY FOR RINARY TRACT INFECTIONS



Discovery of the antimicrobial properties of the nitrofurans provided a novel class of chemotherapeutic agents. These compounds possess specific antibacterial activity with low toxicity for human tissues.

The simplicity and flexibility of this nitrofuran nucleus make possible numerous variations of its chemical and therapeutic ON

characteristics; a remedy may be tailored to fit the disease.

Within recent years we have so designed two important antimicrobial nitrofurans for topical use: Furacin brand of nitrofura-O.N

zone and Furaspor brand of nitrofurfuryl methyl ether.

Now we have succeeded in chemically tailoring a unique molecule, designed specifically for the treatment of bacterial urinary tract infections:



Brand of nitrofurantoin: N-(5-nitro-2-furfurylidene)-1-aminohydantoin.

Products of Eaton Research

for

### pyelonephritis cystitis pyelitis

which have proven refractory to other antibacterial agents:

#### **FURADANTIN**

provides définite advantages:

clinical effectiveness against most of the bacteria of urinary tract infections, including many strains of Proteus, Aerobacter and Pseudomonas species

low blood level—bactericidal urinary concentration effective in blood, pus and urine—independent of pH limited development of bacterial resistance

rapid sterilization of the urine

stable

oral administration

low incidence of nausea-no abdominal pain-no proctitis or pruritus-no crystalluria or hematuria

non-irritating—no cytotoxicity—no inhibition of phagocytosis tailored specifically for urologic use



Scored tablets of 50 & 100 mg. Now available on prescription Write for comprehensive literature



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#### LIABILITY INSURANCE

a doctor-homeowner can get into trouble, a comprehensive liability insurance policy shapes up as highly desirable coverage. In general, such a policy will provide you with financial protection against the following claims (among others):

#### **Sixfold Protection**

1. Claims for injuries to any person (except an office employe) for which you or any member of your household are to blame—whether the person is injured in or away

from your residence. This includes sports accidents.

Medical bills (up to a specified limit) of guests injured on your premises.

3. Claims for injuries that any of your domestic employes may sustain in the performance of their duties. (But such coverage is excluded in some states, where domestics come under workmen's compensation laws.)

Claims for injuries to any person (except a member of your fam-



"Your new drug looks promising all right, Dibbs; but who'll you try it out on?"

# Better Medical Records for every doctor's office the new fashioned way!

The day of laborious long hand notes and paper work is over, Doctor! Today, you talk your records—as you examine, as you treat, or just after the patient leaves. Your records keep pace with your practice. TELEVOICE is unequalled for ease and speed: you talk, she types!

And this valuable service costs only 45¢ to 60¢ a day. Investigate! You'll be glad you did...

TELEVOICE saves you time —enough time to see two to five additional patients per day!





Send for brochure "PHONE Your Medical Records!" No obligation. Just mail the coupon.



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perfamily residing with you), that result from something your servant did in performance of his duty.

Claims for accidental damage to, or destruction of, property (for instance, damage done to a delivery man's truck by a falling tree limb).

Claims for injuries inflicted by your pets, on or off your premises.

This sounds like a lot of protection. It is. To most doctors, it's well worth what it costs.

#### Sixty-Second Baby-Picture Service





Nowadays, the valued first picture of a newborn youngster is often made just minutes after the delivery. In Methodist Hospital, Fort Wayne, Ind., for example, a camera that prints its own pictures within sixty seconds has been permanently rigged to a bassinet. All adjustments are set, so a volunteer worker simply presses a button to take the picture. A minute later, she's set to present the baby's first photograph to the delighted mother. NEW

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> Mucolytic Inhalation Therapy

"Spectacular results"

IN

Laryngitis

Laryngotracheobronchitis

**Bronchopneumonia** 

**Atelectasis** 

**Bronchiectasis** 

**Bronchial Asthma** 

**Tuberculosis** 

WINTHROP

Life Saving in Neonatal Asphyxia

Write for informative literature.

# ALEVAIRE

#### NONTOXIC MUCOLYTIC DETERGENT

Alevaire is administered as a fine mist by aerosol nebulization utilizing a suitable supply of oxygen or compressed air.

"New and uniquely effective method of liquefying respiratory secretions."

Supplied in bottles of 500 cc.

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the syringe you've

been waiting for!

B-D

MULTI

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of an individually fitted syringe

the of a clear glass molded barrel

BECTON, DICKINSON AND COMPANY, RUTHERFORD, N.J.

# Who's Boss In Your Office?

[CONTINUED FROM 139]

reason) the forming of out-of-office friendships with them. Those outside friendships always seem to lead to the desire for preferential treatment, disclosure of confidential information, and perhaps a discussion of my personal life.

#### Your Correspondence

Much of what I've said so far is necessarily negative, for I know pretty well what I don't want in an aide. One positive request of a literate secretary—since she must write many routine notes and letters for my signature—is that she study my general style of conversation and writing. In that way I know that notes explaining Willie's absence from school or my inability to attend a meeting will be consistent with me as I am known.

I also urge my secretary to study me—my routine, my interests, and so on—so that she'll be able to anticipate situations and act for me as I would wish. The girl who can do this is of inestimable value.

#### When Doctor's Away

If my patients identify my staff with me, they'll look to them for help when I have to be out of the office. Injections, diathermy, changing of dressings, and laboratory tests can be taken care of as conditions indicate—if my staff knows my practices and methods.

In my time, I've about run the gamut of possibilities in office employes. One type I've avoided mentioning until now is the willing-butcareless worker who almost bankrupts you by means of burned-out sterilizers, fractured thermometers, broken syringes, and dropped bottles. Her barbed needles, wrong medicines, dirty sheets, and secretion-encrusted specula will also lose you patients.

A careless aide can even get you into some potentially tragic situations. Fortunately, they don't always end on a grim note. I was aghast, one day, to find my nurse giving a woman intravenously a full c.c. of histamine phosphate solution instead of the thiamine chloride she had been getting. Late that afternoon our shaky patient, safely through her collapse, was seen home by taxi. My only hope was that she'd go quietly to another doctor, without suing me.

I was astonished, therefore, to see her in my waiting room a week later, beaming.

"Dr. Hodges!" she bubbled.

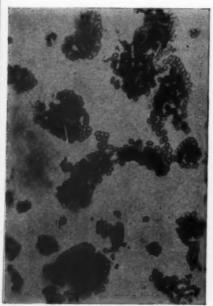
"That wonderful new treatment of yours! I've never had such a sensation in my life."

Neither have I. But the lesson I learned that day simply underscores what I've been saying right along: When it comes to hiring an aide, you can't be too careful.

# **VISUAL PROOF**

The photomicrographs illustrate the action of therapeutic level cobalt in producing actual regeneration of erythrocytes and their precursors even in severely depressed human bone marrow.

Because of extensive clinical studies with RONCOVITE the original cobalt product—this understanding of direct stimulation of the depressed bone marrow has brought a completely new approach to the treatment of "secondary" anemia.



Bone marrow showing—acquired erythrocytic hypoplasia—no nucleated erythrocytes.



Same patient showing—active erythropoiesis following cobalt therapy.

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# ... of the Unique Hematologic Action of Therapeutic Cobalt

#### In Anemia Accompanying Infection—Roncovite

—provides such a significant advance in treatment of this usually refractory condition—acts so dramatically—that in severe cases it may make transfusion unnecessary.<sup>2</sup>

#### In Prolonged "Low-Grade" Anemias—

—where the response to iron is often relatively slow and unsatisfactory—Roncovite produces a 4-fold increase in erythrocyte production and an accelerated rate of hemoglobin synthesis.<sup>3</sup> In these cases Roncovite overcomes the erythropoietic inhibition which has blocked improvement in the blood picture.

Roncovite provides successful therapy in the great majority of *all* the microcytic anemias commonly seen in practice. (Roncovite is of the same low order of toxicity as iron.)

#### Subjective Improvement as Well-

Improvement is often rapid, with the patient voluntarily reporting an increased sense of well being within a few days. Such results have been documented and repeatedly confirmed in clinical use.

Suggested Dosage: One tablet four times daily in adults; 0.6 cc. daily in infants.

## RONCOVITE

#### **DOSAGE FORMS**

Roncovite Tablets—enteric coated, red, each contains cobalt chloride, 15 mg.; ferrous sulfate, 0.2 Gm.; bottles of 100.

Roncovite Drops—each 0.6 cc. contains cobalt chloride, 40 mg.; ferrous sulfate, 75 mg.; bottles of 15 cc. with calibrated dropper.

Write for literature and complete bibliography.

#### LLOYD BROTHERS, INC.

CINCINNATI 3, OHIO

IN THE INTEREST OF MEDICINE SINCE 1870

- 1. Case 2, Seaman, A. J., and Koler, R.; Acta Hematologica, 9:153, 1953.
- 2. Gardner, Frank H., J. Lab. Clin. Med.; 41:56, 1953.
- 3. Rohn, R. J. and Bond, Wm. H.; J. Lancet, 73:301, 1953.

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#### How to Be a Doctor's Wife

[CONTINUED FROM 120]

may be Daniel's patients. If so, learn to appear deaf when the discussion gets personal and specific. Practice that glazed look so no one will get the impression you're in the know about your husband's patients. Don't upset the delicate balance of a private-professional relationship.

A final warning on the subject of social life:

I've always remembered the remark, 'He was all peopled out by the end of the day.' It's not that the doctor doesn't love people, but that he needs rest from the intense personal contact of his work. Keep this in mind when you issue or accept invitations. Activities that call for receptivity rather than participation are usually safe, such as movies and concerts.

Plan your dates carefully. (You're the family's social secretary.) And keep Daniel under a watchful eye.

Don't, for instance, force him to endure people who annoy him. And don't drag him to events that bore him. He'll get nothing out of them, and he'll have that much less good humor left.

I'll write about your community activities in my next letter.

Affectionately,

Lois -



® MEDICAL ECONOMICS

"What's so funny about the doctor saying I'm run down?"



PHOTOGRAPH BY RUZZI GREEN

#### For patients who won't take tablets

#### PENALEV.

SOLUBLE TABLETS POTASSIUM PENICILLIN G

ACTIONS AND USES: Dissolved in a small amount of liquid, PENALEV Tablets make oral penicillin therapy acceptable to small patients who won't swallow tablets. And they also make penicillin dosage easy to regulate in adult patients. PENALEV Tablets are effective in all infections which may be treated with oral penicillin. Also

useful for aerosol therapy and prescription compounding.

DOSAGE: According to the type and severity of the infection.

SUPPLIED: In three dosage strengths-50,000, 100,000 and 250,000 unit tablets in vials of 12 and bottles of 100.

Of 52 acne patients who had ceased to improve with other methods of therapy (including X ray) 63%

showed significant improvement again<sup>1</sup>

On the basis of their good results with KUTA-PRESSIN\* therapy in resistant acre, Pendry and Goldberg\* conclude that KUTA-PRESSIN is "a useful adjunctive method of extending the therapeutic potential in same."

Similarly, other clinicians<sup>3-4</sup> have observed regression of scars, decrease in number of new pusities, and return of more normal skin texture in resistant date treated with KUTA-PRESSIN. Good results have also been reported in respect, pruritus ani, and keloids. <sup>5-7</sup>

SUPPLIED: In 10-cc. and 20-cc. multiple-dose viols; for subcutaneous or intronuscular administration.

> Professional Literature on Request

1. Pendry, M., and Geldberg, N.: New York State J. Med. In proc. 2. Nierman, M. M.: J. Indiano M. A. 45-407, 1922, 3. Knew, J. M. Prollininary report, U. S. Novy Medical Name Letter, vol. 20, Nov. 14, 1952, 4. Indiano, I. L. Clin, Intel. 59:354, 1932, 5. Peels, W. Li To be published. 4. Knils, C. To be published. 7-Marshall, W.: M. Timos 79:222, 1951.

# KUTAPRESSIN

Vennemoriation Principle from Liver

EXTENDS THE "THERAPEUTIC POTENTIAL" IN ACNE



Ethical Pharmoceuticule Since 1894

KREMERS-URBAN COMPANY . Laboratories in Milwoules

Trademark of Kromers-Urban

#### Do Druggists Dispense What You Prescribe?

[CONTINUED FROM 103]

powder—and let the pharmacist make up the nose drops, the ear drops, the ophthalmic solution, the emulsion, or whatever dosage form the doctor prescribes?"

¶ "Having spent four years studying the sciences of materia medica, chemistry, biology, and pharmacology—why should the pharmacist then be transformed into a mere counter of pills and measurer of liquids . . . ?"

Pharmacists have, in fact, launched campaigns in three states—Indiana, California, and New York—to legalize the substitution of one reputable brand for another. But these efforts have apparently got nowhere.

Is widespread duplication of products really the chief cause of substitution? Not according to a couple of authorities quoted by the American Druggist. Here's what they say:

Most substitutes are imitations, not duplicates. Comments Carl K. Raiser, trade relations manager of Smith, Kline & French Laboratories: "In our [national] surveys of prescription filling during 1952, we found that nine out of every ten substitutions were filled with counterfeit products! Not with other distinct brands of the product, but with direct, unmistakable counterfeits."

Druggists exaggerate the duplication problem. Says Benjamin A. Smith, editor of Eli Lilly's Pharmacist's Reference and its Lilly Digest: "Studies of income and expense prove beyond a shadow of doubt that, in stores doing an average amount of prescription business, the prescription department inventory moves at a rate equal to or superior

to that of the inventory of non-drug

MORE→

merchandise."



"Hello, Raymond. It worked!"

#### DO THEY DISPENSE WHAT YOU PRESCRIBE?

Surprisingly enough, according to the survey, Rx substitution seems particularly prevalent in stores that are better than average in sales volume, appearance, and location. It's most common, too, in city stores, because counterfeiting outfits do most of their business in the urban centers. And it's least likely to be found in any of the chain stores, which are generally extremely careful of their reputation. (One well-publicized instance of substitution, for example, could cause doctors to suspect the entire chain.)

#### What Can Be Done

What can be done about substitution? Drug manufacturers, says the report, are now engaging in a triple offensive:

1. To uncover evidence of sub-

stitution, many are hiring special investigators to "shop" drug stores for prescriptions.

To make it easier to prove substitution, some of the manufacturers are identifying their products by secret tracer ingredients, distinctive shapes and colors, embossed symbols or letters.

 To deal with offending druggists, the pharmaceutical manufacturers are increasingly resorting to court action.

The doctors' help is being enlisted, too. By giving a wide berth to known offenders and by reporting any instance of substitution that comes to his attention, the M.D. can play a leading role in the campaign. The physician's pressure, say the druggists, is bound to have a telling effect.

#### Hindsight

• One morning, during my residency on the proctology service of a well-known clinic, I was making rounds to remove anal packs. Entering one of the rooms listed on my card, I asked the patient to roll over on her side. When I lifted up one buttock, I saw no pack. This wasn't too unusual. But closer inspection revealed no evidence of recent surgery, either. I quickly covered the patient, stammered that everything looked fine, and beat a retreat.

A nurse stopped me outside the door and said, "Oh, Doctor, I meant to tell you—that procto case was moved down the hall. The patient in *here* is on the dental service."

—M.D., WISCONSIN

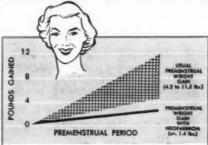
...for those who complain

and those who suffer in silence



# **NEOPARBROM**

#### relieves premenstrual tension



An improved 8-bromotheophyllinate compound, NEOPABBROM acts by reducing the generalized edema characteristic of the premenstrual period.<sup>3-4</sup> Experimental studies<sup>3-2</sup> have shown the ability of this type of compound to counteract the anti-diuretic effect of the posterior pituitary hormone. Clinically, pyrilamine 8-bromotheophyllinate controls premenstrual weight gain (see chart), with concomitant relief of such symptoms as irritability, headache, breast and abdominal fullness, etc.<sup>3</sup>



It has been stated that 40 percent of women suffer from premenstrual tension sufficiently to seek medical help.<sup>1</sup> The percentage would undoubtedly "rise sharply"<sup>1</sup> if interested physicians were to make inquiry on this point a routine part of the case history.

NEOPARBOM\* offers you a safe and sure means of helping not only your patients who complain of premenstrual tension but also those who may admit to symptoms if asked.

SUPPLIED: Bottles of 100 and 500 tablets, each containing 80 mg. of bromaleate, a bromotheophyllinate compound containing 2 molecular weights of 2-amino-2-methyl-1-propanol 8-bromotheophyllinate and 1 molecular weight of pyrilamine maleate.

 Vainder, M.: Indust. Med. & Surg. 20:199, 1951.
 Bickers, W.: Am. J. Obst. & Gyne. 64:587, 1952.
 J. Vainger. M.: Indust. Med. & Surg. 22:183, 1953.
 Greenhill, J. P., and Freed, S. C.: J.A.M.A. 117:504, 1941.

\*Trademark of The Central Pharmacal Co.

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## News

'Militarism breeds socialized medicine,'

says former Congressman • Operating room dedicated to veteran surgeon • New attack on panel-plan medicine •

Newspaper depicts British physician as content with his lot

#### State Supreme Court Rules on \$45 Bill

The focal point of a recent New Jersey Supreme Court case was a doctor's bill amounting to \$45. But while the amount was small, the principle involved was big.

The suit arose from treatment of an injury suffered by a 17-year-old girl in a high-school basketball game. She turned her ankle and fell to the floor but later managed to get home, where her father dismissed the injury as "only a sprain."

Three days later, when the girl continued to hobble, her boy friend's father insisted that she go to a physician. The doctor discovered a fracture and attended to it. In due course, he sent his bill to the girl's family.

The girl's father refused to pay. His contention: Since he hadn't authorized the treatment, he didn't have to pay for it.

New Jersey lower courts backed him up. Said one judge: All precedents hold a child to be "a mere domestic animal, whose necessaries, even in an emergency, are at the father's will."

Finally reversing such judgments, the state Supreme Court ordered the father to pay the doctor's \$45 bill. New Jersey precedents to the contrary, said the chief justice—quoting Blackstone in the majority opinion—"the duty of parents to provide for the maintenance of their children is a natural law."

#### Extols 'Deductible' Blue Cross Plan

There has been a lot of talk about cutting down abuse of Blue Cross insurance by making the patient pay the first few dollars of each hospital bill. In Minnesota, just such a deductible policy is in operation.

Discussing the plan—under which the patient pays \$25 and Blue Cross the rest—Arthur M. Calvin, executive director of the Minnesota Hospital Service Association, says that both Blue Cross and the patients benefit. He explains: [MORE—

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#### Announcing:

Acceptance by the Council on Pharmacy and Chemistry of the American Medical Association of 15 mg.

# Benzedrine\* Sulfate

AMPHETAMINE SULFATE, S.K.F.

# Spansule

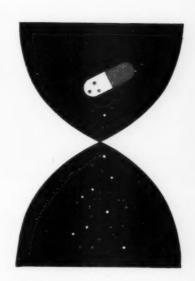


brand of sustained release capsules

'Spansule' sustained release capsules embody the revolutionary oral dosage principle:

uniform release of medication over a prolonged period of time

Smith, Kline & French Laboratories, Philadelphia



\*T.M. Reg. U.S. Pat. Off. for racemic amphetamine sulfate, S.K.F. †Trademark for S.K.F.'s brand of sustained release capsules (patent applied for).

turn to next page

One 'Spansule' capsule provides 10 to 12 hours of uniform therapeutic effect.



In each 'Spansule' sustained release capsule the active ingredient is distributed among many tiny pellets with varying disintegration times. Medication is released gradually, yet uniformly, over a period of 8 to 10 hours, with therapeutic effectiveness lasting for approximately 10 to 12 hours.

sustained therapeutic effect with one 'Spansule capsule.

intermittent therapeutic effect with tablets t.i.d.

#### Fields of use for S.K.F.'s 'Spansule' capsule

The prolonged, uniform release of medication provided by 'Spansule' capsules is now available for the management of depression and for the control of appetite in weight reduction. Smith, Kline & French Laboratories are constantly adapting the 'Spansule' capsule to ever-widening areas of therapeutic use.

X-ray plates demonstrate; sustained, uniform release of medication with Spansule\* sustained release capsules.

> These X-rays show how one 'Spansule' capsule disintegrated through a nine-hour period in a typical subject. The pellets used in this study were specially treated with a radiopaque substance that would not affect their disintegration rate. They have been slightly enlarged and brightened for reproduction in this journal. Their number and position are, of course, unchanged.



8 a.m.

15 minutes after ingestion of one 'Spansule' capsule. The 76 pellets are entirely within the stomach. 11 a.m.

3¼ hours after ingestion of one 'Spansule' capsule. 57 pellets, concentrated in stomach and small bowel, remain.

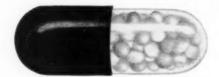
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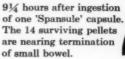
<sup>\*</sup>Trademark for S.K.F.'s brand of sustained release capsules (patent applied for).







2 p.m.
6¼ hours after ingestion of one
'Spansule' sustained release capsule.
32 pellets remain intact: they are in
the small bowel.



1. The "deductible" reduces the cost of a family contract by \$1.60 a month-roughly 20 per cent.

Blue Cross is saved the expense of processing minor claims.

3. Since the patient has to pay part of the bill, he serves as his own "policeman" to prevent unnecessary hospitalization.

Adds Calvin, in a report to Hospital Management: The deductible contract with full service as its base "can be expanded into a true catastrophic type of contract merely by increasing the 'deductible.'"

#### V. A. Reorganized

The Veterans Administration had its face lifted this month. Main effect of the reorganization: to subdivide the agency into three streamlined operating departments: (1) medicine and surgery, (2) insurance, and (3) veterans' benefits.

One mild surprise turned up when the overhaul plans were announced a short time ago. Instead of bringing in a new medical chief, as many observers had predicted, the V.A. said Admiral Joel T. Boone would continue as medical director.

#### Cultists Advised to Tone Down Ads

When even chiropractors object to the side-show flavor of chiropractic advertising, it's news. So the Colorado state board of chiropractic recently made news at its annual meeting by passing a stiffly worded resolution that it "does not countenance flamboyant advertising or in any way the obtaining of patronage through means detrimental to the profession and the public."

The board's proposed solution:

Chiropractors ought to get together and agree on standards to which all chiropractic advertising presumably would have to conform.

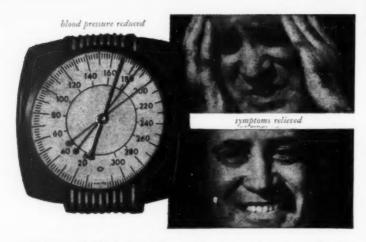
#### Urges Credit for Men Behind Microscopes

Practicing physicians can make a solid contribution to medical research, believes Dr. Ralph W. Gerard, by giving "the poor devils in the laboratories" proper credit for their discoveries.

Dr. Gerard, a physiologist, discusses the matter in a chapter (The Functional Approach to Medical Practice and Education) prepared for a recently published book, "The Epidemiology of Health."

Over and over, he says, the public hears the refrain: "Doctors this, doctors that, doctors find new treatment." Gerard concedes that medical advances are often made by doctors, "but they are mostly Doctors of Philosophy and not Doctors of Medicine. And if the latter, they are rarely in practice."

To Gerard, an M.D.-Ph.D., it's not merely "a matter of justice" but also "a matter of enlightened self-interest" for physicians to set the "Health Education Council, New York, 1953.



## A drug of choice for long term oral treatment of hypertension ... found effective in 81% of patients<sup>1</sup>

Lower blood pressure has been obtained in 81% of moderate and severe hypertensives treated with hexamethonium chloride (available as Methium) under general-practice conditions.\(^1\) In 60\(^6\) of these patients lower pressures continued for 4 to 16 months of the study.

Also, as pressure is reduced, improvement is almost universally seen in eye and heart symptoms, headache, vertigo, dyspnea, etc.<sup>1-6</sup> In some cases even where pressure fails to respond, symptoms may nonetheless abate.<sup>4-7</sup>

Methium, a potent autonomic ganglionic blocking agent, reduces blood pressure by interrupting nerve impulses responsible for vasoconstriction. Because of its potency, careful use is required. Pre-treatment patient-evaluation should be thorough. Special care is needed in impaired renal function, coronary artery disease and existing or threatened cerebral vascular accidents. A booklet of complete instructions for prescribing is available and should be consulted prior to initiating therapy.

1. Moyer, J. H., et al.: Am. J. M. Sc. 225:379 (April) 1953. 2. Mills, L. C., and Moyer, J. H.: A.M.A. Arch. Int. Med. 90:587 (Nov.) 1952. 3. Frankel, E.: Lancet 1:408 (Feb. 17) 1951. 4. Johnson, I., et al.: Texas State J. M. 48:331 (June) 1952. 5. Council on Pharmacy and Chemistry: J.A.M.A. 151:385 (Jan. 31) 1953. 6. Grimson, K. S., et al.: J.A.M.A. 149:215 (May 17) 1952. 7. Turner, R.: Lancet 1:1217 (June 2) 1951.





(BRAND OF HEXAMETHONIUM CHLORIDE)

WARNER-CHILCOTT

Laboratories NEW YORK

record straight. His reason: Research scientists "need the support of the public to keep up their work, to continue to supply the medical profession with new tools for the ever more effective practice of medicine."

It's because the role of the scientist isn't understood, says Gerard, that "the Congress of the United States, a sample of lay opinion, will pour money into institutes labeled with particular diseases while starving the National Science Foundation."

#### Women's Work . . .

Doctors' wives have begun to play a key role in the press relations of the Suffolk County (N.Y.) Medical Society. The women scan local news columns for stories and comments on doctors. If anything unfavorable turns up, they then pass it along to the society, so that it can issue a reply.

#### 'Cheap Repair Jobs Are No Bargain'

An automobile, like a human body, is a complicated mechanism, requiring expert care. So if your car gets banged up in an accident, don't go shopping for a bargain repair job, advises the magazine Business Week. Instead, it suggests, take your auto "to a reliable shop," even if insurance doesn't cover the bill.

Quoting top-flight repairmen, the publication points out that "In the modern car, even a slight dent almost always goes more than skin deep . . . A maze of baffles, struts, compartments, and controls . . . must

#### HAVE YOU CHANGED YOUR ADDRESS RECENTLY?

To insure uninterrupted delivery of your copies of M.E., please return this coupon properly filled out. Address: Medical Economics, Inc., Rutherford, N.J.

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### "DOES THE TAX BITE HURT DOCTOR"

See Page 270



A dividend of twenty-five cents (\$0.25) per share has been declared payable August 20 to stockholders of record August 5, 1953. The transfer records will not close. Bankers Trust Company of New York will mail the checks.

> M. J. Fox, Jr., Treasurer SCHERING CORPORATION Bloomfield, New Jersey



# Organizing and Operating A Group Practice Or Partnership

Now available, as the result of numerous requests from physicians, is a portfolio of reprints on group practice and partnerships. It contains about a dozen of the most requested articles on this subject published in MEDICAL ECONOMICS. The portfolio is book size, with a durable, leatherette cover and with the title stamped in gold. Prepaid price: \$2.

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#### NEWS

be straightened and realigned to return the system" to normal.

So "expect any repair to cost big money," says the magazine. Some examples (counting the cost of labor):

For a new door, you may pay up to \$150. If you need a new front fender, the price may be \$120. Straightening out a little dent may cost you \$35.

Even though high bills for good work may be unavoidable, Business Week concludes, "Never authorize even the smallest collision repair without first obtaining a written estimate . . . Otherwise, the cost may run as high as five times what you might consider fair."

#### Fat of the Land

The austerity-minded British may still be virtually on half rations, but you can't prove it by the physicians of the National Health Service. Last year, at Government expense, they ordered their patients to take more than \$3 million worth of reducing pills.

#### Operating Room Named For 'Grand Old Man'

Applause resounded in the operating room of old Post Graduate Hospital in New York City. The occasion: the dedication of the room to the "grand old man of surgery," 89-year-old John F. Erdmann. Up until two years ago, Dr. Erdmann had per-

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Erythrosulfa\*

erythromycin + triple sulfonamides for combined antibiotic-chemotherapeutic effect in common infections

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formula: each tablet contains

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2 tablets every 6 hours. In severe infections, dosage may be increased to 4 or 5 tablets every 6 hours.

supplied: Bottles of 50

1. Davis, B.D.: Pub. Health Rep. 67:376-379 (April) 1952.

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indicated in

infections resistant to penicillin and other antibiotics.

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mixed infections, including those of the urinary and respiratory tracts.

#### **New Relaxant for**



Consider skeletal muscle spasm as a twisted, knotted rope. Nason's new relaxant tablet, LATRODOL, brings unique relief by unraveling the rope, figuratively speaking, from 3 directions, as shown in the diagram.

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### LATRODOL

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#### NEWS

formed an estimated 20,000 operations in this particular room.

The dedication audience—composed largely of Erdmann's pupils—clapped loudly as the old doctor was wheeled in to witness the unveiling of a plaque. It designates the room as the "Doctor John F. Erdmann Surgical Amphitheatre."

#### Hawley Cites Needless Surgery by Two M.D.s

Says they performed 113 such operations in 14 months

Some of his colleagues charge that Dr. Paul R. Hawley has grossly overstated the prevalence of fee splitting, ghost surgery, and unnecessary operations.

But Hawley, insisting that this is not the case, writes in the Bulletin of the American College of Surgeons that "Scarcely a week passes in which prima facie evidence of [these practices] does not reach [us]."

One recent case cited by the A.C.S. director: The College was requested by "the trustees and medical staff of a small hospital to audit the surgical work of two of their active staff surgeons," who were suspected of performing a large number of unnecessary operations.

Making a "five-day, on-the-spot study," an A.C.S. investigator checked 879 operations performed during the preceding fourteen months—not only by the two surgeons in question but by ten other



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surgeons as well. The key finding:

There had been 140 unnecessary operations-forty-seven by surgeon number one, sixty-six by surgeon number two, and twenty-seven by the ten other surgeons combined. The first two surgeons had operated unnecessarily 24 per cent of the time, reported the investigator.

The record of unnecessary surgery by the rest of the staff: 6 per cent (which Dr. Hawley regards as normal).

Other discoveries reported to the A.C.S. director by the investigator:

¶ The two surgeons under suspicion concentrated on unnecessary appendectomies (not incidental to other operations), performing fortyone of them. Of the twenty-one unnecessary appendectomies performed by surgeon number two, eighteen were on children no older than four.

The two surgeons performed eighteen unnecessary sterilizations and twenty-five unnecessary hysterectomies. One hysterectomy patient

The hospital's "pathologists were only too willing to cooperate in returning agreeable pathological diagnoses." In fact, despite A.C.S. findings to the contrary, "a careful analysis of the pathologists' reports revealed that normal tissue was practically never removed by these surgeons."

Commenting on the report of his investigator, Dr. Hawley says "Regardless of indignant denials, this

#### PROMPT RESULTS In Contact Dermatoses Clinical evidence (1) shows nothing protects skin like Silicote Silicone Ointment . . . because only Silicote provides the new HOUSEWIFE'S silicones in a non-watery base. Not easily washed away, Sili-**ECZEMA** cote protects skin from contact irritants, and allows underlying tissues to heal. Many formerly intractable cases respond in 24 to 48 hours. Silicote is non-occlusive, and permits skin DIAPER function. A simple, specific formula, non-irritating and non-RASH sensitizing. OCCUPATIONAL DERMATOSES

1. Jl. Inves. Derm., 17:125 (Sept., 1951)

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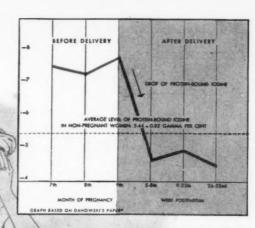
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Endocrine Factor in Postpartum Fatigue?

> Fatigue and other nonspecific postpartum complaints, which many women experience for weeks and even months, now may not have to be accepted as one more burden that goes with motherhood. Consistently lower serum protein-bound iodine values as found in a series of healthy young women studied during the first year postpartum suggest the existence of a state of relative hypofunction of the thyroid.\* Thyroid medication appears to be the physiological answer in this condition, to hasten recovery.

Thyrar provides whole gland thyroid medication at its best. Prepared from beef sources exclusively, thyrar undergoes dual standardization, chemically assayed and biologically tested. Thyrar is of superior uniformity.

How Supplied: Tablets of 1/4, 1 and 2 grains in bottles of 100 and 1000.

\*Danowski, T. S., et al.: Am. J. Obst. & Gynec. 65: 77-80, 1953.



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PHYSIOLOGIC THERAPEUTICS THROUGH RESEARCH

From where I sit



Hear About the Electric Weather Predictor?

Squint Smith built up quite a reputation last month by predicting the weather. What he said usually came true.

It got so that folks would sit around his little Antique Shop just to get his opinion.

Last Monday, though, he said he didn't know. That surprised us and when we asked what happened, Squint said, "Slipped up on my electric bill and was turned off. I'll get to my radio again tomorrow though." Squint had been getting the weather over the radio—just like anyone else!

From where I sit, that's the way it goes with some "experts." They often don't have any more inside information than you can get for yourself. Like those who would tell their neighbors how to practice their professions . . . or those who "know" cider is the only thirst-quencher. Far as I'm concerned, I'll take a glass of beer. But—I won't try to "predict" your choice for you.

Joe Marsh

Copyright, 1953, United States Brewers Foundation

College can document every statement made about fee splitting, ghost surgery, and unnecessary surgery."

The A.C.S. doesn't know what percentage of physicians indulge in such practices, concedes Hawley. "But we can say that our own records show that they are far too prevalent."

#### Find Insurance Covers Most Hospital Days

Every other day spent in a Connecticut hospital now is covered by Blue Cross. Patients themselves make direct payments for only fifteen hospital days out of 100.

These are the findings of a study made by the Connecticut Hospital Association. Here's the breakdown:

- Blue Cross pays for about 50 per cent of patient-days in hospitals.
- 2. Commercial insurance pays for about 24 per cent.
- Workmen's compensation insurance pays for 3 per cent.
- 4. The state, cities, and towns pay for 8 per cent.

Result: Individuals foot the bills for just 15 per cent of the days spent in hospitals.

#### The Name's the Same

Maybe there's something in a name, after all:

¶ In San Diego, Calif., Dr. Paul Wedgewood shopped around for a hobby and decided—naturally—on ceramics.

[MORE→

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Before Using Riasol



After Using Riasol

# Persistent Psoriasis cleared with

The clinical file cards of physicians who have used RIASOL in the treatment of psoriasis show remarkable results. In some cases the thick crusted lesions had been present for many years without any remission, in spite of various local medications.

When RIASOL is applied according to directions, the results in stubborn cases of psoriasis may appear almost unbelievable. Patches which have been present for years may disappear in weeks.

Physicians who have been discouraged by slow, uncertain results with chrysarobin, tar, salicylic acid and other local medications are invited to try RIASOL. Not only are therapeutic results usually better, but local irritation is largely avoided as well

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

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RIASOL FOR PSORIASIS

¶ In Bridgeport, Conn., hospital M.D.s weren't a bit surprised to learn that the Martin Kane who'd turned up for repairs was a detective. Not the radio-TV private eye, it developed, but a real, live member of the Bridgeport police force.

#### Dollar Drive Urged for Mental-Disease Study

Maisel article raises hope that cures can be found

America badly needs an "Association Against Mental Disease," just as it has needed, and benefited from, associations set up to fight cancer and infantile paralysis.

That's the conclusion reached by magazine writer Albert Q. Maisel in an article, "Is Mental Disease Mental?" in the Ladies' Home Journal.

Maisel states the views of medical men who believe research may find physical cures for many mental ailments. But, he notes: "The sad truth is that there are only a handful of scientists working full time on research against the mental diseases." Main reason: "No other field of research receives less financial support . . ."

Maisel feels that a high-powered national campaign could change this picture quickly.

Of course, there already is a National Association for Mental Health. But Maisel notes that it turns over no more than \$100,000 a year to research. By contrast, organizations



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SEPTISOL'S cumulative action keeps on killing bacteria — even

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ME-9-53

# "Stuffy head"

You know when... and which... nasal instillations are desirable. But, the patient who wants relief from a "stuffy head"... does he consider such things as rebound congestion, ciliary damage or other hazards of indiscriminate self-treatment?

Novahistine, taken orally, usually reduces nasal congestion promptly. It can eliminate use of topical applications between office visits and "overtreatment" by the patient.

The vasoconstrictor agent<sup>(1)</sup> in Novahistine causes no cerebral excitement and does not lose effectiveness with repeated dosage. Its decongestant action is potentiated and supplemented by one of the most effective, least-toxic of the histamine antagonists.<sup>(2)</sup>





# **NOVAHISTINE**

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Each teaspoonful or tablet provides:

(1) Phenylephrine hydrochloride. 5.0 mg. (2) Prophenpyridamine maleate . 13.5 mg.

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Division of Allied Laboratories, Inc. • INDIANAPOLIS, INDIANA

\*TRADEMARK

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that stage spectacular drives collect millions for their research.

One financial oddity of the mental-disease situation, says Maisel, is this: While funds spent on mental-health research this year total less than \$3 million, the states and the Federal Government are spending more than \$500 million merely to feed and house the mental patients "we do not know how to cure."

#### Mirror, Mirror . . .

Hauled in by Denver police for practicing chiropractic without a license, a Pennsylvanian explained that "I do not diagnose, but analyze. I do not prescribe, but advise." He added that people "are not patients but subjects." And he described himself as an "iriologist"—one who sees disease mirrored in the eyes.

#### Propose Ethics Changes To Fight Panel Plans

Brooklyn doctors want to kill H.I.P., its president charges

Up in arms over the tactics of closedpanel medical plans, Brooklyn (N.Y.) doctors recently put their collective weight behind a pair of resolutions that strike at the heart of such medical practice.

Despite the vigorous opposition of medical men associated with the Health Insurance Plan of Greater New York—principal target of the



Alfred P. Ingegno
Warns the public to look twice

attack—the resolutions were supported by almost 80 per cent of the 1,032 medical men who filled out ballots.

The anti-H.I.P. resolutions state no new principles. Rather, they expand principles already set forth in the A.M.A. code of ethics.

1. To the A.M.A. ban on advertising by physicians, the Brooklyn doctors would append this statement: "It should be understood that any medical care plan... which advertises for subscribers and directs such subscribers to a restricted panel of physicians is advertising for the benefit of the physicians involved."

To the A.M.A. dictum that "The right of a patient freely to choose his doctor must be preserved and maintained," the Brooklyn medical men would add this amplifica-

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1 or 2 three times daily. Supplied: Bottles of 100, 500 and 1000.

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2 to 4 teaspoonfuls three times daily. Supplied: Pints and gallons.

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#### NEWS

tion: When a "third party...agrees to provide...services through the medium of individual or group practice...any requirement restricting choice of physician to either the individual or group practitioners under contract vitiates the subscriber's right to free choice of physician. This is against the best interests of the public and of the medical profession."

Announcement of the resolutions was coupled with a statement by Dr. Alfred P. Ingegno, president of the Kings County medical society, that the proposals should serve as "a warning to the public to look twice before it joins any health plan which restricts free choice of physician."

H.I.P.'s reaction—voiced by its president, Dr. George Baehr: The Kings County society is trying to destroy "all non-profit health insurance plans" and turn back the clock a hundred years. [MORE→

#### Anecdotes

¶ MEDICAL ECONOMICS will pay \$10-\$25 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

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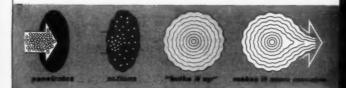
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was tor's mor and Added H.I.P. in a statement to the New York World-Telegram and Sun: "H.I.P., with its extensive coverage, offers the only alternative to national compulsory health insurance if America's millions are to get the medical care they deserve."

Replied the Kings County society: "Actually, it [H.I.P.] is privately sponsored socialized medicine, run by a group of individuals, the same as if it were run by a group of government bureaucrats."

The newspaper displayed these and other quotations on its front page under an eye-catching headline: "MD War Flares Over Health Plan."

#### **Country for Doctors**

So few physicians are voluntarily entering rural practice that serious consideration is now being given to national legislation that would compel all new M.D.s to spend their first year in the hinterlands.

Who is seriously considering this step? The Government of Yugoslavia.

#### This Family Doctor Has A Special Specialty

The 13-year-old boy who dropped into Dr. Porter K. Mason's Dallas (Tex.) office on a recent rainy day wasn't ill. He explained to the doctor's secretary that his problem was money. Seems he'd gone to a movie and then got caught in the rain with-

out enough carfare to get home.

"When the doctor isn't busy, will you ask him if I can borrow two cents?" the boy asked. The doctor's aide advanced him a nickel.

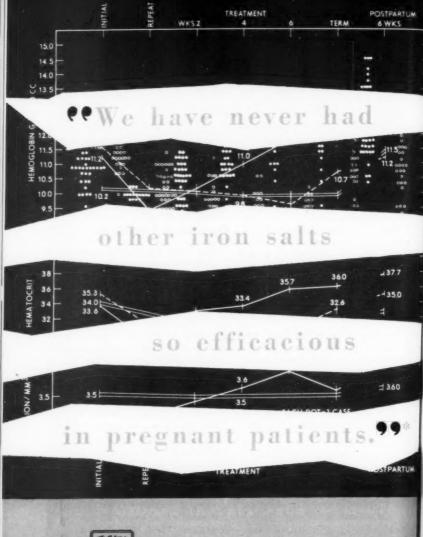
Later, the boy's parents told Dr. Mason that when they'd scolded their son for borrowing money, he stubbornly pointed out that "He's our family doctor, isn't he?"

#### 'Happy' British Doctor Profiled in Lay Press

New York Times plays up good points of health service

Beginning his sixth year as a practitioner of socialized medicine, George Thomas Harper of Upper Waldrop, England, "gives every appearance of being a happy man...he is agreeably surprised to find out that he has kept his professional freedom, and that his relationship with his patients is still satisfying."

With those rosy words, London correspondent Clifton Daniel introduces "Dr. Harper" to the readers of the New York Times Magazine. While the doctor's name and home town are fictitious, Daniel carefully notes that the central character of his article ("A British Doctor Weighs the Health Service") is a real flesh-and-blood physician, a 42-year-old veteran of World War II, who had distinct qualms about entering socialized practice originally. "We thought it would be disastrous," says Harper. "We felt that if the patients



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<sup>\*\*</sup>As in streptomyces fermentation extractives.

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mol-iron with calcium and vitamin D

—for pregnant and lactating patients.

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-palatable, prophylactic drop dosage.

\*Dieckmann, W. J., and Priddle, H. D.: Anemia of Pregnancy Treated with Molybdenum-Iron Complex, Am. J. Obstet. & Gynec. 57:541-546 (Mar.) 1949.

WHITE LABORATORIES, INC., KENILWORTH, N. J.

\*Complete bibliography on request

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#### Now available, for functional constipation

## A significantly new development

## ... a safe, effective peristaltic stimulant without side effects

When Harrower investigators isolated the laxative principle of prunes and identified it as a diphenyl isatin, they made a contribution to therapy which was truly and significantly new. Now the synthetic analogue of this isatin is available in two products for the therapeutic correction of functional constipation.

#### ISOCRIN

Diacetylhydroxyphenylisatin (Harrower) is supplied as a 5 mg. tablet for single-dose laxation. It is prompt, non-irritating and completely free from side effects because there is no systemic absorption.

#### PRULOSE COMPLEX

In tablet or liquid form combines the isatin principle, as represented in Isocrin, with balanced proportions of methylcellulose for moist bulk. Clinical results indicate that the combination exceeds, in therapeutic effect, the acknowledged advantages of methylcellulose alone.

Isocrin is usually prescribed for acute or occasional needs, while Prulose Complex is indicated for physiological correction where the added advantage of a bulking agent is desired. At times Isocrin is used to precede or supplement corrective therapy with Prulose Complex. Used together or separately according to circumstances, the two products offer complete flexibility and professional control of dosage for every conceivable laxative requirement.

A note on your prescription pad or letterhead will bring samples, dosage information and clinical reports.

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This initial opinion didn't immediately change, writes Daniel. Dr. Harper was stunned by the "vast increase" in his work load. About 1,800 patients signed on with him in his first year as a socialized M.D. He now handles about 4,000 patients, with the aid of an assistant.

On a typical day, Daniel writes, Dr. Harper is visited by thirty to fifty patients; and he may make as many as thirty house calls on top of that. Main result of this, says Harper: "One has to cut out the frills."

What frills remain are reserved for Harper's 150 or so private patients, who prefer to pay their own bills. Says he of this "old brigade": While these patients receive no better treatment, "I am prepared to consider their convenience and comfort more."

Aside from the size of his patient load, he has two other objections to the National Health Service:

 He has an "indefinite . . . feeling there's a sort of power behind the scenes . . . a third party between you and the patient."

2. He feels that the patient "has the whip hand," largely because the service "was designed for the benefit of the patient rather than the doctor."

Surprisingly, Dr. Harper doesn't voice one stock objection to the health service: that it entangles doctor and patient alike in red tape.

There's not much interference

either, says Harper; and "So far as clinical treatment is concerned, one has complete freedom. You do whatever you feel is justified."

What pleases Harper most about socialized practice is that he's doing relatively well financially. In his last year of private practice, Harper figures he netted the equivalent of about \$4,000. He upped that to about \$5,500 in the first year of health service and has been doing somewhat better since then.

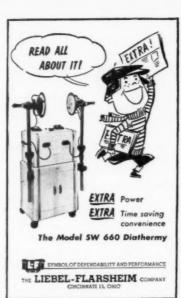
All things considered, Dr. Harper figures that he's making out "as well as I would have done if I had remained in private practice." In addition, says Daniel, Harper feels a new "sense of security," because he doesn't have to "worry about whether his patients can pay."

The reader is likely to leave the Daniel article with at least one definite impression: that on the scale Dr. George Harper uses to weigh socialized medicine, the good points far outbalance the bad.

#### Outlines Easy-Does-It Fee Approach

In a new book, "Price Practices and Price Policies," which includes a chapter on professional fees, economics professor Jules Backman of New York University tells the story of an optometrist who initiates his son into the business with this advice on charging:

"When you give the glasses to the
"The Ronald Press, New York, 1953.





#### NEWS

patient, say, 'That will be \$20,' and pause. If the patient doesn't seem disturbed, then add, 'for the frame.'

"Then say, 'There will be a charge of an additional \$20.' If the customer makes no protest, add, 'for each lens.'"

#### Pronounced Perfect

A recent medical graduate of the University of Illinois was given nation-wide publicity for a remarkable scholastic record: During nineteen years of formal education, he'd maintained a "straight A" average. But this "A" is almost the only vowel he has to his name: John C. Przypyszny.

#### 'U.S. Still Menaced by Socialized Medicine'

Former Congressman warns of danger in 'militarism'

Militarism is leading America down the road to socialism, says former Congressman Howard Buffett of Nebraska. He makes—and amplifies—this charge in a recent article for the publication Human Events.°

Here's the full text of Buffett's article, which is entitled "Backing Into Socialized Medicine":

"Socialized medicine ought to be a dead issue in America. In a number of elections its advocates have taken repeated shellackings, to the point where candidates for office

Human Events is headquartered at 1835
 K Street, N.W., Washington, D.C.

# Anxieties about feeding totaled 33 per cent



A record of complaints made by 100 mothers of normal newborn infants illustrates in striking fashion the extent to which baby's "eating and digestion" constitute a source of maternal anxiety. Of 178 complaints cited by Carithers, a total of 58 (or 33 per cent) were concerned with problems related to feeding.

1. Carithers, H. A.: J. Pedias. 38:654 (May) 1951

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hardly dare mention it. This situation is testimony to the political effectiveness of the doctors who fought socialized medicine, as well as to the fact that Americans will reject any socialistic proposal that is properly labeled; that is why the word 'socialism' is assiduously avoided by its avowed proponents, like the New Dealers or the Americans for Democratic Action.

"Nevertheless, we are edging towards socialized medicine, whether we want it or not. We are being dragged into it as a result of our attempt, since Pearl Harbor, to meddle in the affairs of the world. We are backing into it by way of militarism.

"Out of World War II emerged over 15 million American veterans, each with a lifetime claim on the Government for free medical care—subject to some conditions. Then there are about 3.7 million men and women now in uniform who have a 'plus' claim on society for medical attention; the 'plus' is the inclusion of their dependents and families in the subsidy. To be exact, the 'plus' is not entirely free, for the dependents are required to pay certain modest charges for such medical

services as they receive.

"Altogether, there are almost 20 million Americans, mostly on the underside of 50, who enjoy this special attention.

"The Government has sought to lessen this continuing strain on its budget by attaching some technical re-



Howard Buffett Warns againsi 'meddling abroad'

strictions to the use of the privilege. The regulations call for dividing all medical cases into two broad classifications, service-connected and nonservice-connected. An ailment that can be positively traced to service duties entitles the veteran to free and unlimited medical attention for the rest of his life. Non-service-connected disabilities are treated free in veterans' hospitals only if the patient signs an application in which he declares his inability to pay. His signature is final; it is not checked or questioned in any way. The idea is to protect the ailing veteran from embarrassment.

"Naturally, most post-service health troubles are post-service developments; we all acquire more miseries as we get older. Also, like most of us, veterans have their finan-

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1. Dripps, R. D.: Selective Utilization of Barbiturates, J.A.M.A. 139:148 (Jan. 15) 1949.

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cial troubles. It is not strange, therefore, that a recent survey came up with the statistics that 64 per cent of veteran hospital beds were occupied by patients suffering from non-service ailments. That left only a third of the available beds for service-connected cases, which explains why so many deserving veterans were kept on the waiting list. Quite a headache for the Veterans Administration.

"The financial and medical difficulties arising from the claims of veterans already on the rolls are as nothing to what looms ahead. Under the Selective Service law, about 900,000 young males are conscripted each year, and conscription automatically entitles them to medical care for the rest of their lives-according to regulations. Should Selective Service, often referred to as sugar-coated Universal Military Training, be converted into fullfledged U.M.T., in a comparatively few years at least half the nation's population-not counting dependents-would have a claim on Uncle Sam. M.D. Since U.M.T. would be a continuing process, the claim on said doctor's services would grow and grow.

"Nor does the problem stop there. As the Government siphons off the medical personnel needed for sick veterans or soldiers in service, the talent available for the civilian population diminishes. The V.A. now employs 7,000 doctors regularly and an equal number on call. This cre-



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Oster, K. A., and Golden, M. J.: Exp. Med. & Surg., 7:37, 1949

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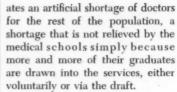
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"This false scarcity of doctors creates the very conditions which the advocates of socialized medicine decry. Following the law of supply and demand, the fees of the fewer available doctors rise. And as a matter of necessity, their offices are overcrowded and their examinations are often forced to be hasty and perfunctory. Thus the inflammatory charges of the socialists acquire substance—if one overlooks the cause of the condition, which is the absorption of a large part of our medical profession by the military.

"Yet, the facts indicate that the hullabaloo about the shortage of doctors in America is just hullabaloo. In 1940, before the war, there was no shortage. In fact, there was a shortage of patients, for many young and well-trained doctors were finding it difficult to establish practices. What then happened to create the present apparent shortage?

"In 1940 there were 175,382 medical doctors in the United States. By 1952 the number had increased to 211,680, a gain of 36,298. To be sure, the population of the country had increased by 15 per cent—but the doctor population had increased by 21 per cent.

"Where are all these doctors? As



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stated above, a good portion of them are in the employ of the Veterans Administration. But, many more are in military uniforms, stationed wherever American troops are stationed. The Army has one doctor for every 275 men and women in the service. The Navy personnel seem to be more fragile; they need a doctor for every 195 men in uniform. The Air Force, somewhat less demanding, gets along with a doctor for every 315. While those in combat areas could understandably be in need of such liberal medical service, most of the military forces are, thank God, not so occupied, and on the whole they constitute the healthiest segment of our entire population.

"As for the rest of us, we must get along with one doctor to 710 possible patients. Whether that is adequate we do not know. But, we do know that many of our small communities cannot secure permanent doctors; and we do know that the available civilian doctors are carrying a heavy load. None of us, not even the overworked doctors, would complain about this condition, if it were created by the need of medical attention on the battlefield, or even in the service hospitals. There is a suspicion, however, that the large ratio of doctors to men in uniform is in line with the program of those who would collectivize America.

"A government that conscripts its youth is under obligation to provide

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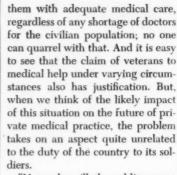


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"The doctor who enters the Army directly from medical school, or after his interneship, knows nothing but bureaucratic medicine, and has no experience by which to measure its disadvantages. Just as the young graduate who goes to Washington









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immediately after he receives his diploma soon makes a perfect mental adjustment to statism, so the doctor in uniform learns how to get along by pleasing his superiors (not his patients), and how much easier it is to make reports than diagnoses. Besides, the regularity of the pay, though inadequate, is an immediate inducement that offsets the promise of the future in private practice. Why hang up a shingle and wait for patients? The Government has lots of them. And why fret about fees and collections? The monthly check from the Government is always good.

"So then, socialized medicine can slide into the American way of life without any new legislation. This would be all right to those who are hell-bent for socialism. To those of us who have always known that militarism and socialism are related, the situation is dark; unless we can get rid of militarism we cannot prevent the coming of socialism.

"Perhaps the solution of this problem lies with the doctors who know of the dangers to medicine, both as a science and an art, in socialization. They have thus far put up a good fight, and maybe they can figure out a maneuver to prevent the destruction of the profession by the flank movement from militarism. Perhaps the young doctors can be taught that regimented medicine is bad for them and the country.

"To those who refuse to see the danger in the present trend, and

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who view the situation as a temporary post-war phenomenon, I offer a bit of history. The Civil War ended in 1865. But the largest number of pension recipients was not reached until 1915, 50 years later, when 691,606 Civil War pensions were being paid. The peak of expenditures for Civil War pensions was reached in 1921. From this experience it is fair to conclude that the medical demands arising from our two World Wars will grow with the years, and will continue to provide the advocates of socialized medicine with plausible argument.

"The veterans are not to blame for this situation. They bear little or no responsibility for it. When they were drawn into the bloody and futile overseas ventures, they were entirely too young and inexperienced to pass judgment on the policies that disrupted their lives, or to understand what the consequences of these ventures would be. One can express disappointment, however, that their leadership has not supported the small band of patriots in and out of Congress who have resisted the drainage of our economy to the point where future payments to widows, orphans and wounded will be of questionable value. The continuing wastage of our wealth since World War II, by way of handouts, while working into the hands of our socialist-minded, must in the end weaken the nation's ability to discharge its solemn duty to the veterans.'



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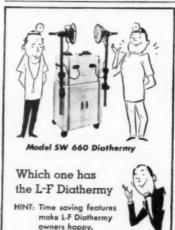
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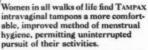


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New York Pharmaceutical Co. 202 Num Specialty Co. 200
Organon, Inc. 201 Ortho Pharmaceutical Corp. Insert between 64, 65
Parke, Davis & Co.     278       Patch Company, The E. L.     72, 269       Pelton & Crane Co.     154       Pet Milk Company     14       Pfizer & Co., Chas.     72, 105, 105, 107, 298
Insert between 64, 65
Reed & Carnrick 152 Reynolds Tobacco Company, R. J. 34 Ritter Company, Inc. 71 Robins Co., Inc., A. H. 54, 55 Insert between 96, 97
Roerig & Co., J. B.   70
67, 247, 248, 249, 250 Insert between 32, 33
Smith Co., Martin H. 84 Spencer, Inc. 215 Spencer Industries 288 Squibb & Sons, E. R., Division of Mathieson Chemical Corporation 76 Strasenburgh Co., R. J. 164 Tailbu Neor Co. 259
Mathieson Chemical Corporation         76           Strasenburgh Co., R. J.         164           Tailby-Nason Co.         258           Tampax Incorporated         294           Tarbonis Co., The         287           Taylor Instrument Companies         68           U. S. Brewers Foundation, Inc.         262           U. S. Vitamin Corporation         22, 23           United Surgical Supplies Co.         288           Upjohn Company, The         30, 31, 51, 255, 256, 257
Wampole & Co., Inc., Henry K 48, 49
Warter-Chicott Laboratories 69, 148, 252 White Laboratories, Inc. 156, 157, 211, 272, 273 Whitehall Pharmacal Co. 182 Winthrop-Stearns, Inc. 293 World Medical Association 293 Wyeth, Inc. 176, 259
°In specified territories.

# Memo

#### FROM THE PUBLISHER

### Reader Service

"I'd like information about general practice sections in hospitals."

Or: "How can we set up an emergency call bureau?"

Or: "I have to make a talk on the economics of medicine. Can you help me?"

When readers write us like this, we *can* help, and *do* (to the extent of a good many thousand letters and reports a year).

But we'd like to help *more*. And that brings me to the point of this memo:

We can be of greatest help only when the reader helps himself first. By that I mean: We can supply data that will best answer a physician's problem only if we know what the problem is—specifically and in detail.

No source of information like MEDICAL ECONOMICS is (as people sometimes seem to think) omniscient. That's why, time and again, we have to write a reader to this effect:

"We have your inquiry about general practice sections in hospitals, and we'll be glad to supply whatever information we have or can get. But we must first ask you to explain more precisely what you want to know.

"Do you simply need background data about G.P. sections? Or do you want aid in starting a section? Or do you want to know where G.P. sections now function? Or what?

"Once you've thought your problem through, please state it in the form of as many carefully thoughtout questions as you can. (Such questions, prompted by us, often total more than a hundred on a single topic.)

"Next, tell us what sources or types of sources you think might provide the best information."

Often we send a reader back-copy articles that help him. But more often he needs information that's newer or more comprehensive or that covers phases of the topic not dealt with before. Fresh research is then called for; and, if it seems worth while, we're happy to spend the necessary time and money on it.

Our main requirement is that the information sought be of enough economic interest to the medical profession at large. If it is, and if the reader will work with us by furnishing acceptable questions and leads, we'll do our utmost to get results.

If you have a problem, then, that concerns, say, personal business, or practice management, or public relations, or your medical society committee work, call on us. MEDICAL ECONOMICS offers you without charge its facilities across the country. We hope you'll look upon it as your own private economic research agency.

—LANSING CHAPMAN

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No. 3: "Instructions for Bathing Your Baby." No. 4: "The Hygiene of Pregnancy."

No. 5: "Home Care of the Bedfast Patient."

No. 6: "Sick Room Precautions."